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Colorado Office of the State Auditor

Evaluation of the Colorado Department of Health Care Policy & Financing's Medicaid Recovery Audit Contractor Program

May 2024

OFFICE OF THE STATE AUDITOR
C O L O R A D O

Submitted by:

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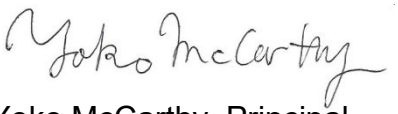
REPORT NUMBER 2356P

BerryDunn

May 24, 2024

Members of the Legislative Audit Committee:

This report contains the results of a performance evaluation of the Medicaid Recovery Audit Contractor (RAC) Program at the Department of Health Care Policy & Financing (HCPF). This evaluation was conducted pursuant to Section 25.5-4-301(3.7), C.R.S., (House Bill 23-1295), which requires a review of the RAC Program for compliance with applicable requirements and standards, and an examination of policy recommendations. The report presents our findings, conclusions, recommendations, and policy considerations, and the responses and comments of the Department of Health Care Policy & Financing.



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Contents

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Report Highlights

Evaluation of Colorado's Medicaid Recovery Audit Contractor Program

Department of Health Care Policy & Financing

Performance Evaluation • May 2024 • 2356P

Key Concern

The Department of Health Care Policy & Financing's (HCPF) Medicaid Recovery Audit Contractor (RAC) program generally adheres to federal and state requirements, but HCPF needs to improve contract oversight and program management to help ensure the program operates efficiently and as intended to reduce Medicaid overpayments and improve provider billing.

Key Findings

- Three of 31 audits conducted by HCPF's RAC applied inconsistent, unclear, or outdated policies which resulted in some inaccurate findings, and inefficient use of HCPF and provider resources for findings that were rescinded.
- HCPF pays its RAC based on overpayments found through audits, even if they are not recovered from providers, which is contrary to federal and state requirements and could incentivize overzealous audits.
- HCPF does not directly verify that its RAC's staff have contractually-required credentials. HCPF stated that it relies on the RAC's national accreditation to provide assurance in this area, but HCPF lacked evidence that 31 of 61 RAC staff had required licenses or certifications.
- When HCPF's Medicaid fiscal agent acquired the RAC in 2021, HCPF did not obtain required disclosures related to conflicts of interest. Also, HCPF has not communicated to Medicaid providers that a conflict does not exist.
- HCPF has not provided clear guidance on its limits on the number of claims or records that can be reviewed in a RAC audit or ensured that the RAC offers provider outreach and education as the contract requires, reducing program effectiveness in improving provider billing practices.
- This report provides policy considerations to improve the RAC program related to improving proper provider billing and ensuring timely reconsideration or appeals of audit findings.
- The evaluation found that the period covered by RAC audits, called the lookback period, could be reduced to the federal maximum without a substantial change in recoveries, while reducing provider burden.
- The report includes a policy consideration for HCPF to reevaluate the 18 percent fee it pays its RAC and the ability to require the RAC to identify underpayments to providers.

Background

- Medicaid is a federal-state program that provides 1.7 million eligible low-income Coloradans with health care coverage and services through about 93,000 service providers.
- HCPF administers Medicaid in Colorado and is responsible for ensuring compliance with applicable federal and state requirements and that expenditures are appropriate.
- Federal law requires states to contract for RAC audits of paid Medicaid claims to help ensure payments to providers are appropriate. States may obtain a federal exemption from the law and Colorado is one of 18 states with a Medicaid RAC program. HCPF contracts with Health Management Systems, Inc., as its RAC.
- Providers must repay overpayments identified through RAC audits, and the state must repay the federal government its portion of the overpayments. In Fiscal Year 2023, HCPF recovered about $47 million in overpayments due to RAC audits.

Recommendations: 18

Department Responses

Agree: **17**

Partially Agree: **0**

Disagree: **1**

Policy Considerations: 8

Chapter 1: Evaluation Overview and Background

Medicaid is a federal-state program that provides health care coverage and services to eligible low-income individuals. Medicaid is administered at the federal level by the Centers for Medicare & Medicaid Services (CMS) under Title XIX of the Federal Social Security Act. In Colorado, the Department of Health Care Policy & Financing (HCPF) is the designated agency responsible for administering and overseeing Medicaid. Colorado's Medicaid program is commonly known as Health First Colorado.

In Colorado, Medicaid represents approximately 37% of the State's budget, or $14 billion in Fiscal Year 2023. The federal government covers a share of state expenditures for Medicaid, called the Federal Medical Assistance Percentage (FMAP), which is based on economic conditions in the state, and varies based on the types of services provided and the populations being served. The FMAP for Colorado Medicaid expenditures typically ranges from 50% to about 56.2% but can be as much as 90% for certain eligible individuals.

HCPF is responsible for ensuring that Medicaid expenditures are appropriate and that the State complies with all federal and state Medicaid requirements. Federal regulations [42 CFR § 440] require states' Medicaid programs to provide all eligible recipients certain basic services, including, but not limited to, inpatient and outpatient hospitalization, physician and rural health clinic services, and nursing facility services for recipients aged 21 and older.

In Fiscal Year 2023, there were about 1.7 million eligible Medicaid beneficiaries in Colorado and roughly 93,000 Medicaid providers. Medicaid providers include a variety of health care entities, such as physicians, hospitals, laboratories, hospice providers, medical equipment suppliers, and imaging services providers. Providers submit claims to HCPF for the services they provide, and the claims are processed and paid by HCPF's fiscal agent – Gainwell Technologies – through the interChange System. Providers must follow national medical coding and billing standards, federal regulation, and HCPF Medicaid policy manuals when submitting health care claims through interChange. Medical coding is the translation of treatments, services, and patient diagnoses into a standardized numeric code to determine how much a provider is owed for services rendered.

Recovery Audit Contractor Programs

State Medicaid agencies, such as HCPF, employ a variety of procedures and programs intended to help ensure that payments to Medicaid providers are appropriate—that payments are made only for services provided, that were medically necessary, that were offered in compliance with Medicaid regulations, that were accurately coded, and that were billed within regulatory time frames. One of these key programs is the Medicaid Recovery Audit Contractor (RAC) program. Beginning in 2010, states were required by federal law to establish RAC programs to review paid Medicaid claims to identify underpayments and overpayments made to providers, and recoup any overpayments identified. Overpayments are payments that do not

meet Medicaid program guidelines and can occur due to provider improper billing practices, errors, and misapplication of billing policy. Providers must repay any amounts found to be overpayments through a RAC audit, and the state must repay the federal government the federal portion of the overpayment.

As shown in **Exhibit 1**, as of December 2023, there were 18 states, including Colorado, with active Medicaid RAC programs.

Exhibit 1: States with Medicaid RAC Programs as of December 2023

Arizona	Mississippi
California	Nevada
Colorado	New Mexico
Connecticut	New York
Georgia	North Carolina
Hawaii	Oregon
Illinois	South Carolina
Indiana	Texas
Minnesota	West Virginia

Source: BerryDunn RAC State Research.

RAC programs are especially important given that most Medicaid claims do not require preapproval of the services before providers serve Medicaid recipients. RAC audits help state departments that administer Medicaid, including HCPF, fulfill their fiduciary responsibly to ensure Medicaid funds are only used for allowable purposes and spent appropriately. According to CMS, RAC programs can also be beneficial by encouraging actions that help prevent future improper payments, such as by educating providers so that they can avoid submitting claims that do not follow Medicaid requirements.

Colorado's RAC Program

Under federal regulations, states must either contract with an eligible vendor to provide RAC services or have a State Plan Amendment (SPA) approved by CMS to be exempted from the requirement. HCPF's first contract for RAC services began in July 2011. From July 2013 through June 2016, HCPF suspended the RAC program, with CMS approval, because it was unable to secure a qualified contractor. Since July 2016, HCPF has contracted with Health Management Systems, Inc. (HMS) to serve as the RAC.

Federal regulations establish requirements for all state Medicaid RAC programs, but also allow states significant flexibility in designing their programs. **Exhibit 2** cites key program design elements of Colorado's RAC program and the related federal provisions.

Exhibit 2: Colorado Medicaid RAC Program and Federal Provisions

Colorado Features	Federal Provision
Scope of services audited by the RAC program. Applies only to fee-for-service claims in Medicaid. The program does not audit Medicaid managed care claims or fee-for-service dental claims.	States have the discretion to determine what areas of their Medicaid programs to target for RAC review and may exclude claims based on the program integrity landscape in the state, including all managed care claims.
Lookback period. Colorado has an approved State Plan Amendment allowing the RAC to review claims up to seven years old from the date the claim was paid.	The RAC must not review claims that are older than three years from the date of the claim, unless CMS approves an exception.
Contingency fee for RAC contractor. Colorado has a CMS-approved State Plan Amendment to pay a contingency fee of up to 18% of overpayment amounts recovered.	The contingency fee paid to a RAC may not exceed the maximum specified by CMS, unless CMS approves an exception. The maximum federal rate for most claims is 12.5%.
Paying to identify underpayments. Colorado has a CMS-approved State Plan Amendment that exempts HCPF from the requirement to pay the RAC to identify underpayments.	States must determine the fee paid to a Medicaid RAC to identify underpayments. States must adequately incentivize the detection of underpayments.
Appeals. Colorado statute and regulations allow providers to appeal RAC findings through an administrative review. HCPF allows providers to seek Informal Reconsideration of a finding in addition to a formal appeal.	States must provide appeal rights, under State law or administrative procedures, to Medicaid providers that seek review of an adverse Medicaid RAC determination.
Source: BerryDunn analysis of federal regulations, 42 CFR § 455 (F), and FAQs issued by CMS in December 2011.	

The RAC Audit Process

RAC audits occur on a cyclical basis throughout the year. The process starts with HMS analyzing the entire population of fee-for-service (FFS) paid claims to identify trends and patterns that might indicate potential audit areas. HMS then develops audit plans, which HCPF and HMS refer to as “scenarios,” that are expected to identify overpayments. Scenarios are reviewed by HCPF and, if approved, HMS completes the audit. Each audit scenario is designed to identify overpayments associated with a specific set of medical codes, common policy, or benefit rules, and reviews specific claim types (e.g., outpatient, inpatient, professional claims) to determine if they have been billed in error.

Colorado RAC audits are classified into two types - automated and complex, as follows:

1. Automated audits involve data analysis queries and algorithms to compare paid claims data to applicable billing, coding, utilization, and reimbursement rules and policies. Automated audits are conducted when improper payments can be clearly identified from the claim itself, such as claims for services rendered after a patient’s date of death;

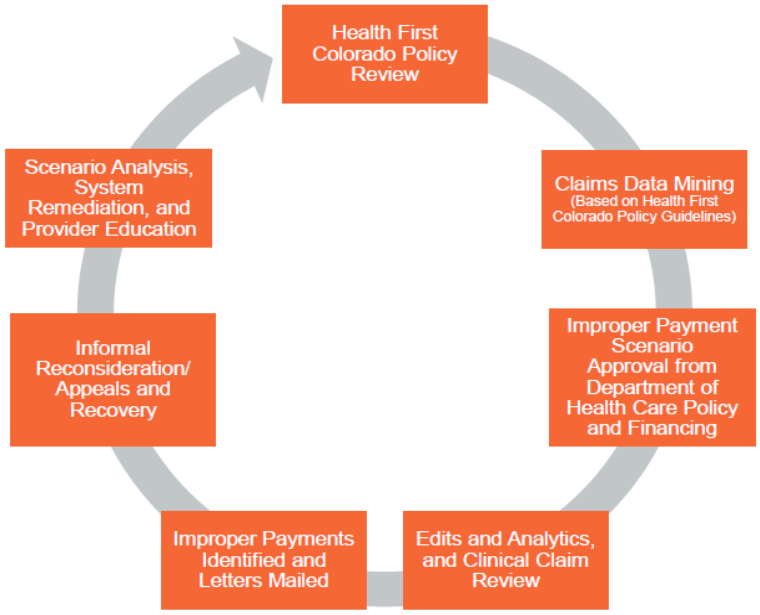
claims for services rendered to recipients no longer eligible for Medicaid; and duplicate claims for a given service. Automated audits do not require examination of medical records for each claim, although according to HCPF, HMS staff may manually review audited claims data in comparison to Medicaid rules and regulations, as a means of quality assurance.

2. Complex audits involve examination of medical records supplied by the provider to determine if the records document the appropriateness of the service and the accuracy of the billed medical claim. Any claims for which the provider does not supply the requested records on time are deemed to be overpayments, per regulations. An example of a complex audit scenario is improper billing for hospice services. Billing for hospice care can be complicated because the care is interdisciplinary, involving physicians, nurses, social services, and medical supplies. In addition, hospice services may be reimbursed at one of four care levels: routine home care, continuous home care, inpatient respite care, and general inpatient care. To assess whether a hospice claim was properly billed, HMS must review medical records for sufficient documentation that the claimed services were provided and necessary. Such documentation may include a certification by a medical professional that the individual is terminal and has a prognosis of nine months or less and evidence that the Level of Care provided was justified, especially for claims for continuous home care, which is the most expensive Level of Care.

Once HMS completes its review of data and documentation on an audit, HMS prepares finding letters for HCPF's review. If HCPF approves the finding letters, HMS sends a Notice of Adverse Action/Overpayment (Notice) to each provider for whom audits have identified claims as having overpayments. The Notice sent to each provider includes a demand for repayment with a deadline and outlines the provider's rights to request an Informal Reconsideration and/or appeal, which are described later in this chapter.

HMS conducts RAC audits of 31 different claim scenarios, and the audit process can vary depending on the type of audit conducted and claim areas being reviewed; however, the general audit process is depicted in **Exhibit 3.**

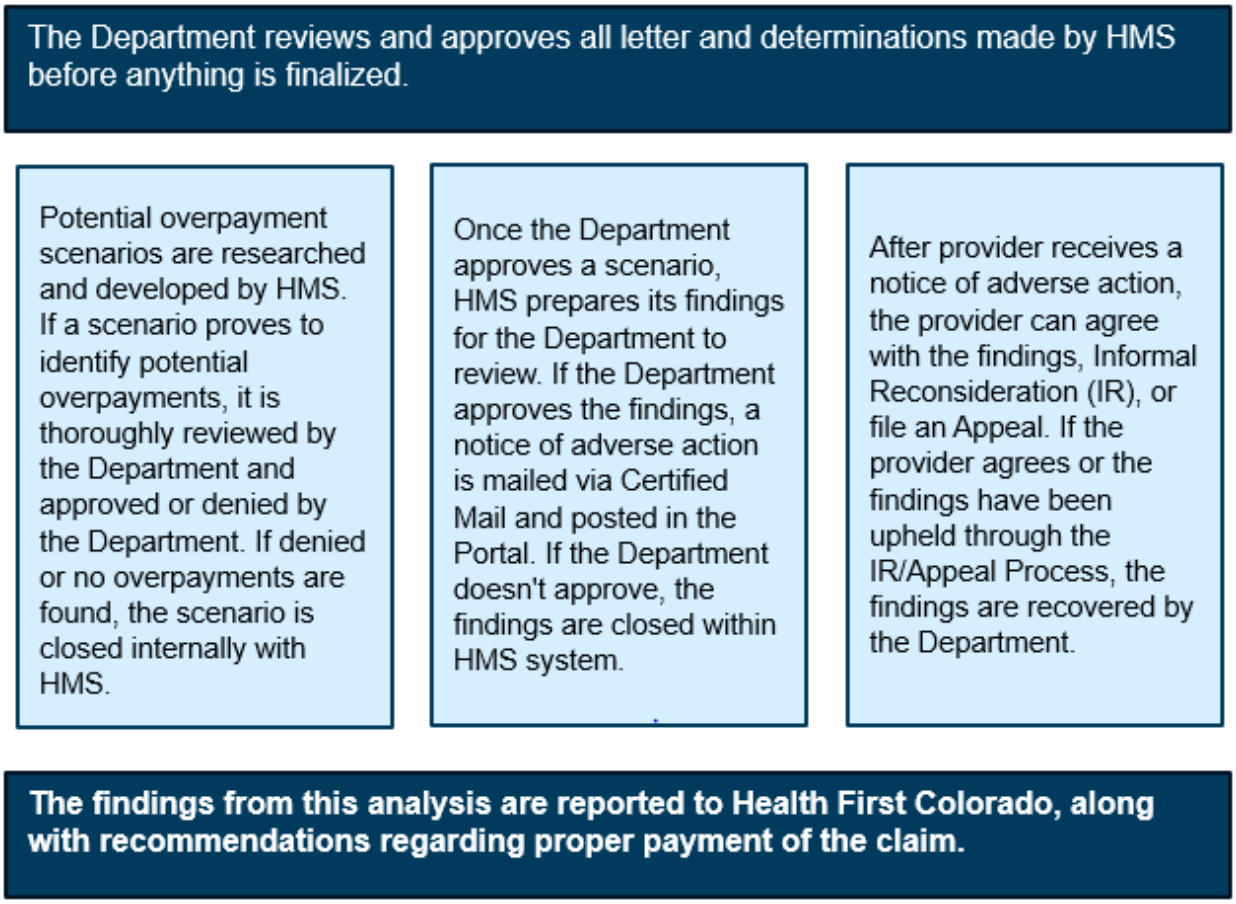
Exhibit 3: HMS RAC General Audit Process



Source: CO RAC Overview Presentation 12.10.20.pptx (live.com)

HCPF also plays a key role in the RAC audit process. For example, as shown in **Exhibit 4**, HCPF staff are responsible for reviewing and approving the RAC audit scenarios proposed by HMS, as well as the audit findings.

Exhibit 4: HCPF's Review Role in RAC Audit Process



Source: https://resources.hms.com/state/colorado/rac "RAC Automated Process" (PowerPoint).

In addition to planning and conducting audits, HMS is responsible for provider outreach, which includes informing providers about the audit process and deadlines, the rights and responsibilities of all parties involved in the audit, and the resources and tools available to providers. HMS is also responsible for provider education, which includes creating and presenting information regarding the audit, including applicable federal regulations, audit procedures, and communication resources, to providers, legislators, and stakeholders. HMS must create educational materials and have them approved by HCPF before distributing them to the public.

Recoveries of Overpayments

According to information provided by HCPF, RAC audits by HMS have resulted in annual recoveries from overpayments identified during the audits. **Exhibit 5** summarizes the overpayments that HCPF reported as recoveries in Fiscal Years 2019 through 2023.

Exhibit 5: Colorado RAC Program Recoveries of Overpayments

Fiscal Year[1]	Overpayments Recovered
2019	$793,180
2020	$1,411,280
2021	$8,574,530
2022	$26,395,210
2023	$47,090,740

Source: Figures provided by HCPF.
1 - The Fiscal Year for the State of Colorado is July 1 through June 30.

Recoveries of overpayments have increased over time for a number of reasons. First, according to HCPF, when HMS began administering Colorado's RAC program in 2016, it audited fewer years of past claims payments in order to allow providers time to learn billing requirements and to correct their billing methods. Second, Colorado's Medicaid population grew during the Covid public health emergency, which resulted in an increase in claims that were audited and a corresponding increase in unallowable payments that audits identified. Third, HCPF reported that it took a cautious approach to auditing providers during the public health emergency by pausing RAC audits for certain months and for rural hospital providers, slowing the pace of sending audit findings and requests for documentation to providers to allow them time to respond, and granting providers extensions. Fourth, HCPF and HMS have increased the number and types of RAC audits conducted over time, which has resulted in more recoveries of overpayments in recent years.

When overpayments are identified during a RAC audit, providers have four options to return the funds to the State. Providers can choose from the following options:

1. Arrange an Electronic Funds Transfer
2. Arrange an offset against their future claims reimbursements
3. Arrange a payment plan by contacting HCPF's RAC Contract Manager
4. Remit payment to HCPF via check.

Informal Reconsiderations and Appeals

Federal regulations [42 CFR § 455.512] and state statute [Section 25.5-4-301, C.R.S.] require HCPF to have a process for providers to contest the findings of any RAC audit. HCPF offers both an Informal Reconsideration process and a formal appeals process, as described below.

Informal Reconsideration. A provider has 30 days from the date it receives a Notice to request an Informal Reconsideration of the findings by HMS. The request must be in writing, identify the specific overpayment the provider is contesting and the reason, and be accompanied by additional documentation to support the request. HMS' contract states that it has 35 days to review all new and previous documentation that a provider submits associated with the audit

findings, and HMS decides whether to maintain or reverse the findings. According to HCPF, HMS provides all Informal Reconsideration documentation, along with HMS' decision letters, to HCPF for its review and approval. If approved, HMS notifies the provider of its decision. The letter informing a provider of HMS' Informal Reconsideration decision includes information on the process and deadline the provider must follow if it wishes to appeal the decision.

Appeal. Providers have the right to appeal a finding through the Office of Administrative Courts within the Colorado Department of Personnel & Administration; providers do not have to request an Informal Reconsideration prior to filing an appeal. Providers have 30 days to file an appeal after the date of the Notice, or after the date of the Informal Reconsideration Determination. HCPF may choose to settle appealed findings with the provider. If this route is chosen, the provider and HCPF discuss and potentially compromise on the terms of the settlement, such as the amount of repayment owed or the specific services in question. HCPF stated it considers broader program objectives and other factors when deciding whether to settle an appeal, including but not limited to, administrative efficiency, the cost of appeals to the RAC program, the extent to which the provider participated in the Informal Reconsideration process, the relevancy of additional medical documentation submitted by the provider during the appeal, and maintaining positive relationships with providers. If no settlement is reached, then the case progresses through the administrative review process, and if not resolved, will be heard and decided by an Administrative Law Judge within the Office of Administrative Courts.

Evaluation Purpose, Scope, and Methodology

House Bill 23-1295, codified in Section 25.5-4-301, C.R.S., required the Office of the State Auditor (OSA) to contract with an organization that had experience in reviewing Medicaid State Plans and amendments to conduct an independent review of HCPF's Medicaid RAC program during Fiscal Year 2024. To conduct the review, the OSA contracted with BerryDunn, a consulting and certified public accounting (CPA) firm that serves state, local, higher education, and quasi-governmental agencies.

BerryDunn has extensive experience and expertise in health care consulting and auditing, clinical coding and documentation, and health care compliance. It employs clinicians, certified coding and documentation specialists, and health care compliance professionals. The BerryDunn team assigned to this review includes nursing professionals with expertise in compliance and risk management, quality improvement, and program integrity in a range of government and health care environments, including state Medicaid agencies; individuals who hold certifications by the American Academy of Professional Coders (AAPC), including but not limited to: Certified Professional Coder (CPC)®, Certified Outpatient Coder (COC)®, Certified Professional Medical Auditor (CPMA)®, and Certified Documentation Expert Outpatient (CDEO)®; Medicaid compliance specialists; and data analysts.

Section 25.5-4-301(3.7), C.R.S., outlined 14 objectives for the review, as shown in **Exhibit 6**.

Exhibit 6: RAC Program Evaluation Objectives

Statute	Chapter Reference
1. Evaluate compliance with CMS requirements for Medicaid RAC programs, state law, and coding practice standards. [Section 25.5-4-301(3.7)(a), C.R.S.]	Chapter 2, Finding Nos. 2 and 4; Policy Considerations B and C. Chapter 3, Finding No.7
2. Examine the effectiveness and level of the payment model used for HCPF's RAC, including the level of payments sufficient to maintain a contractor, the scope of the contract and deliverables, and impacts on providers related to a contingency fee-based system significantly above the federal standard. [Section 25.5-4-301(3.7)(a)(I), C.R.S.]	Chapter 2, Finding No. 2 Chapter 3, Policy Consideration H
3. Examine the methods and effectiveness of HCPF's approach to addressing provider concerns regarding the Medicaid RAC program. [Section 25.5-4-301(3.7)(a)(II), C.R.S.]	Chapter 3, Finding No. 7
4. Examine the requirements imposed by other states regarding overall RAC contractor staffing and qualifications for reviewers to help ensure alignment of specialty and subspecialty expertise for conducting initial audits and final determinations. Consider how Colorado can optimize staffing to balance potential overpayment claims and medical necessity reviews. [Sections 25.5-4-301(3.7)(a)(III)(A) & (3.7)(b)(II)(B), C.R.S.]	Chapter 4
5. Examine other states' lookback periods and their relative financing mechanisms. Consider the impacts on providers and Medicaid beneficiaries of a lookback period in Colorado that exceeds federal standards for Medicaid RAC programs. [Sections 25.5-4-301(3.7)(a)(III)(B) & (3.7)(b)(II)(A), C.R.S.]	Chapter 3, Policy Consideration D
6. Examine other states' best practices, or best practices recommended by providers, to help improve billing practices and compliance and to provide support throughout the RAC audit process. [Section 25.5-4-301(3.7)(a)(III)(C), C.R.S.]	Chapter 3, Finding No. 7
7. Examine the feasibility of incentives for underpayment identification, including models from other states. [Sections 25.5-4-301(3.7)(a)(III)(D) & (3.7)(a)(VI), C.R.S.]	Chapter 3, Policy Consideration H
8. Assess the implications for providers and the State's General Fund of adjusting the lookback period used for RAC audits. [Sections 25.5-4-301(3.7)(a) (III)(D) & (3.7)(a)(VI), C.R.S.]	Chapter 3, Policy Consideration E
9. Examine, compare to other states, and, to the extent feasible, disaggregate by service date, audit finding date, and provider type: a. The number, proportion, and value of claims reviewed relative to total potential claims subject to the RAC program. b. The number and proportion of providers impacted by claims reviews and contested payments.	Chapter 4

Statute	Chapter Reference
c. The number, proportion, and value of contested payments, including underpayments, overpayments, and recoupments. d. The number, proportion, value, and result of contested payments by disposition status, including resolution through Informal Reconsideration and appeal. [Section 25.5-4-301(3.7)(a)(IV)(A) – (D), C.R.S.]	
10. Examine provider administrative burdens associated with the RAC program. [Section 25.5-4-301(3.7)(a)(V), C.R.S.]	Chapter 3, Policy Consideration F
11. Examine the impact of audits on provider participation and access to care, and opportunities to increase meaningful provider participation access to care. [Section 25.5-4-301(3.7)(a)(VII), C.R.S.]	Chapter 3, Policy Consideration F and D
12. Assess the duplication of utilization management reviews and approvals, such as prior authorization, with post-payment and audit reviews. [Section 25.5-4-301(3.7)(a)(VIII), C.R.S.]	Chapters 3, Policy Consideration F
13. Assess federal flexibilities that Colorado can use to improve the RAC program, including provider education, training, and error rates, and the timing and procedure when a potential overpayment is "identified" or "determined." [Sections 25.5-4-301(3.7)(b)(I), (3.7)(b)(II)(E), & (3.7)(b)(II)(C), C.R.S.]	Chapter 2, Policy Consideration A
14. Consider how the State could evaluate the cost benefit of the RAC program to determine whether it is striking the right balance between accountability and access to care. [Section 25.5-4-301(3.7)(b)(II)(D), C.R.S.]	Chapter 3, Policy Consideration G
Source: BerryDunn analysis of Section 25.5-4-301 (3.7), C.R.S.	

This evaluation was performed from August 2023 through May 2024.

We developed and executed a work plan for this review that relied on both quantitative and qualitative methodologies. In particular, we obtained information from HCPF, publicly available sources, other states, providers, and provider associations. HCPF provided us with, and we reviewed, more than 11,000 unique documents as part of our evaluation process.

Work performed on the evaluation involved the following key areas of activity:

- Interviewed HCPF staff responsible for the administration and oversight of the Colorado RAC program.
- Interviewed HMS staff related to our review of a sample of audited claims as well as for understanding of HMS' role and responsibilities in the program.
- Reviewed RAC program documents from the following RAC program areas:
    a. Requests for Proposals (RFPs) issued to procure a RAC vendor over the entirety of Colorado's RAC program
    b. RAC program contracts in effect from July 2016 to the present

c. RAC contract transmittals
d. RAC audit scenarios
e. RAC program policies and procedures
f. Policies and procedures related to the appeals and Informal Reconsideration processes
g. Internal RAC program process documents
h. Notices and communications sent to providers

- Reviewed federal regulations and guidance pertaining to the Medicaid RAC program and contacted CMS for information about Colorado's RAC program.
- Reviewed Colorado statutes and regulations pertaining to the RAC program and other Medicaid post-payment reviews.
- Interviewed four provider associations regarding their experiences with the RAC program. Because of the interviews' limited and voluntary nature, the results are only representative of the associations and providers that participated, and cannot be projected to any broader populations.
- Conducted a voluntary online survey of Colorado Medicaid providers that are subject to RAC audits. The purpose of the survey was to gauge perceptions and attitudes of providers about the RAC program. The survey was active from 10/31/23 – 11/27/23, and we received 115 valid responses. The survey methodology and results are included in Appendix A. Because of the design and voluntary nature of the survey, the results are only representative of those providers that responded. The survey results are not representative of and cannot be projected to any group of providers or the provider community as a whole.
- Conducted online research to gather information on the RAC programs in the 17 other states that had programs as of December 2023.
- Contacted eight other states with RAC programs for information on aspects of their programs and audit statistics (Georgia, New Mexico, New York, North Carolina, Oregon, South Carolina, Texas, and West Virginia). We interviewed representatives of five of these states (Georgia, New York, Oregon, South Carolina, and Texas). To determine which states to contact, we asked HCPF which RAC programs it considers most similar to Colorado and we selected states that varied in the size and scope of their RAC programs, their lookback periods, and their RAC vendors. This variety provided us a broad perspective on how different RAC programs operate.
- Analyzed aggregate data on Medicaid claims that were audited by the RAC vendor between January 2018 and June 2023.
- Reviewed a sample of 100 of the 482,509 paid Medicaid claims that were audited by HMS between January 2018 and June 2023. The sample consisted of 76 claims that underwent automated audits and 24 that underwent complex audits. The results of our sample testing are not intended to be projected to the population. However, they are

valid for corroborating some of the information we received from providers and identifying potential weaknesses in RAC audit processes, as discussed later in this report.

- Reviewed all 31 audit scenarios that HCPF had approved for use during the period covered by our evaluation. We reviewed for the completeness of the scenarios and their compliance with the requirements in the RAC contract. For three of these scenarios, we conducted more detailed examination of documents related to the scenarios, including the findings, correspondence, evidence of Informal Reconsideration reviews, and appeals. These three scenarios were selected based on case review findings and data, and during the reviews we noted potential problems with the scenario designs.

We appreciate the cooperation and assistance provided by HCPF and providers during this evaluation.

Obtaining the views of responsible officials is an important part of our commitment to ensuring that the report is accurate, complete, and objective. Drafts of this report were reviewed by HCPF management and staff, and they had opportunities to provide us feedback. We were solely responsible for determining whether and how to revise the report, if appropriate, based on the HCPF's comments. The written responses to the recommendations and the related implementation dates were the sole responsibility of HCPF. However, we included an Addendum to HCPF's responses if they were inconsistent or conflicted with our findings or conclusions, or if they did not adequately address the recommendations.

Chapter 2: Evaluation of Compliance with Federal and State Requirements

The purpose of the Medicaid Recovery Audit Contractor (RAC) program is to identify overpayments and underpayments made on claims for health care services provided to beneficiaries and to help recover overpayments. Federal regulations outline requirements for state Medicaid RAC programs and require states to implement the programs in compliance with state law.

House Bill (HB) 23-1295, which is incorporated into the Colorado Revised Statutes at 25.5-4-301(3.7), required this evaluation to review compliance with federal regulations and State statutes pertaining to the Medicaid RAC program. Overall, our review found that HCPF's RAC program is designed and operating in a manner that achieves its purpose, that is consistent with its approved State Plan Amendment, and that adheres to most of the key requirements in federal regulations and State statute. However, we identified some areas where the program is not in full compliance with some requirements. **Exhibit 7** below provides a summary of key federal and State requirements for RAC programs and our conclusions on HCPF's compliance with them.

Exhibit 7: Key Requirements for Medicaid RAC Programs

Key Requirements for Medicaid RAC Programs [1]	In Compliance?
Contracting for RAC Services	
States must contract with an eligible RAC to review paid Medicaid claims to identify underpayments and overpayments.	Yes
Lookback Period	
A RAC must not review claims that are older than three years from the date of the claim. HCPF's Medicaid State Plan Amendment (SPA), which is approved by the Centers for Medicare & Medicaid Services (CMS), allows the RAC to review claims up to seven years old.	Yes
RAC Compensation	
States pay RACs a contingency fee based on a percentage of overpayments recovered. The fee may not exceed that specified by CMS, which is 12.5% for most claim types. HCPF's CMS-approved SPA authorizes a contingency fee of up to 18%.	Yes
States pay RACs a contingency fee based on a percentage of overpayments recovered.	No, see Finding 2
Qualifications of RAC Personnel	
The RAC must demonstrate its technical capability to carry out its duties and employ trained and licensed medical professionals and certified coders.	Partial. See Finding 4

The RAC must employ a 1.0 full-time equivalent (FTE) medical director who is a licensed Doctor of Medicine or Osteopathy. HCPF's CMS-approved SPA allows the RAC to hire a 0.10 FTE medical director.	Yes
Identification of Underpayments	
States must set a fee for the RAC to identify underpayments and must adequately incentivize the detection of underpayments. HCPF's CMS-approved SPA authorizes an exception to the fee.	Partial. See Policy Consideration H
Program Operations	
RAC programs must offer education and outreach that informs providers about audit policies and protocols, customer service measures including a toll-free telephone number, and methods to accept electronic submission of medical records.	Partial. See Finding 7
States must provide appeal rights to providers seeking review of an adverse RAC determination. Statute outlines appeal rights.	Yes
States must coordinate RAC audits with other audit entities. RACs should not audit claims that have been or are being audited by another entity.	Yes
Cases of suspected fraud and/or abuse found through a RAC audit must be referred to an appropriate law enforcement agency.	Yes
States must set limits on the number and frequency of medical records to be reviewed by the RAC.	Yes
Source: BerryDunn analysis of RAC program requirements and HCPF's RAC program. 1 - Requirements summarized from federal regulations at 42 CFR § 455 Part Subpart (F),, and state statute at Section 25.5-4-301, C.R.S.	

Statute also required that we evaluate "compliance with coding practice standards." Current Procedural Terminology (CPT®) codes offer health care professionals a uniform language for coding medical services and procedures to streamline billing and reporting and increase accuracy and efficiency. CPT codes are also used for administrative management purposes, such as claims processing and developing guidelines for medical care review. The CPT is a standard code set—outlined in Health Insurance Portability and Accountability Act (HIPAA) regulations—used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. We found that HCPF's coding/billing manuals generally follow industry standards for coding, including the use of CPT codes for Medicaid claims.

Finding 1 – Audit Scenario Investigation

According to the RAC contract, HMS must prepare a written audit "scenario" and receive HCPF approval of the scenario before starting an audit. Each scenario describes a set of paid claims that have overpayments or are likely to have overpayments and provide specific information, including whether the audit will be automated or complex, the standards each claim will be measured against to determine if an overpayment occurred, the estimated number of claims to be reviewed in the scenario, and the provider type(s) that will be audited. Scenarios are reviewed by not only HCPF's RAC program staff, but also by other HCPF staff, including those with Medicaid program and policy expertise and responsibilities. For example, a scenario that proposes to audit Home and Community Based Services (HCBS) claims will be reviewed by RAC program staff and staff from the Office of Community Living, which oversees the HCBS waiver within HCPF. Currently HMS reviews claims for 25 automated audit scenarios and six complex audit scenarios.

What Work Was Performed, and What Was the Purpose?

During our evaluation, we conducted high-level reviews of 31 scenarios, and we conducted a more extensive evaluation of three audit scenarios based on case review findings and data and noted potential problems with the design of the scenarios. The Level of Care audit scenario was conducted between February 2018 and June 2023, and the Radiology Duplicates and the Billing of Inpatient Visits audit scenarios were conducted between August 2022 and April 2023. For two of these scenarios (Radiology Duplicates and Level of Care), the audits resulted in a significant proportion of findings that were rescinded by HCPF after the providers had been notified of the original findings. For the third scenario (Initial Inpatient Visits), our analysis of HCPF's report of claims audited indicated that as of February 9, 2024, roughly 58.5% of the findings had undergone an appeal and 59.6% of findings had undergone an Informal Reconsideration. In addition, according to the information from our survey and interviews with providers, the Initial Inpatient Visits audit created confusion and frustration for providers due to inconsistency in the guidance HCPF had provided for coding and billing the services covered by the audit. As of February 9, 2024, the Informal Reconsiderations had been completed and HMS had upheld all the findings, but none of the appeals had been concluded.

To further assess these three scenarios, we reviewed the following documentation for each one:

- The written scenarios HMS submitted to HCPF, and documentation of HCPF's review and approval of the scenarios.
- HCPF Provider Bulletins and other guidance on proper billing for the services covered in each of the three scenarios.
- Correspondence from February 2018 and June 2023, and other materials (such as a settlement agreement) that explained how HCPF dealt with the claims during the appeals process.

We also discussed the audit scenarios with HCPF and HMS.

The purpose of our work was to assess the controls HMS and HCPF had in place to ensure that scenarios were complete and accurate before the audits were conducted.

How Were the Results of the Work Measured?

HCPF's RAC contract requires HMS' scenarios to include specific information, including details on the standards (i.e., professional coding manuals, Medicaid benefit plans, State and federal regulations, reimbursement policies, contracts, billing instructions, and claims processing edits in effect on the dates of service) that pertain to the audit. The audit scenarios take into consideration the Date of Service on the provider submitted claim and the effective date of each criterion for the audit. [Contract Section 1.15.1.2] The contract stipulates that, for each of these standards, the scenario must include the citations and the full text of the regulation, policy, instruction, etc. [Contract Sections 1.13.1.4.1 - 1.13.1.4.3] These requirements provide information that HCPF RAC and policy staff need in order to review and approve audit scenarios. This information is also used to provide HCPF policy staff the rationale for the audit and information on the utilization of certain billing practices, as well as to develop the case summaries made available to providers as part of the audit.

HCPF's review and approval is intended to validate the scenario, including that the standards that will be used in the audit are complete and accurate. If there are any changes to the manuals, plans, regulations, or policies after an audit scenario is approved by HCPF, the approved scenario should be reevaluated and potentially updated to help ensure accurate audits of claims.

What Problem Did the Work Identify?

We found that each of the three scenarios we reviewed used standards to identify findings, which were inconsistent, unclear, or outdated at the time of the audit, as described below.

Radiology Duplicates Audit Scenario. HCPF approved this automated audit scenario in June 2022 and the audit was completed in March 2023. Six months after the audit was completed, HCPF rescinded all the findings from the audit due to a conflict between the guidance some providers received from HCPF related to billing for radiology services and the official rules and manuals that HMS used for the audit. For this audit, HMS applied a lookback period of 2015 through 2020. On June 1, 2018, which was during the lookback period, HCPF changed its billing policy related to radiology (per provider bulletin B1800417). As a result, some of the claims in this audit would have been submitted by providers and paid under the old policy (i.e., the policy in effect prior to June 1, 2018) and some were submitted and paid under the new policy (i.e., the policy effective beginning June 1, 2018). In the scenario, HMS recognized the change in policy and indicated that it would test claims against the policy in effect when the claim was submitted. However, it appears that HMS policy staff and RAC program staff did not know that HCPF had informally provided guidance to some providers to begin billing according to the new policy *before* June 1, 2018. Providers that followed this guidance had claims that were identified as improper when the Radiology audit was conducted. In total, this audit identified $13.5 million in overpayments to 17,000 providers.

Level of Care Audit Scenario. The Level of Care inpatient audit is part of the larger Inpatient Audits**.** HCPF approved this complex scenario in February 2017, and the first audit began in February 2018. After the initial audit, in 2021 HMS conducted additional reviews under this scenario with a lookback period that included Calendar Year 2019. In 2023, HCPF retracted many of the findings from the 2021 reviews because the audit scenario had not been updated to account for a change in policy that occurred in February 2019 for treatment of End Stage Renal Disease (ESRD), which is one of the services covered by the audit. As a result, some of the ESRD claims in the 2021 reviews would have been submitted and paid under the old policy (i.e., the policy in effect prior to February 2019) and some were submitted and paid under the new policy (i.e., the policy effective beginning February 2019). The 2021 reviews did not account for this change; they tested all claims against the old policy, so all claims billed after the policy change in February 2019 were identified as overpayments.

HCPF retracted findings from the Level of Care audit that had been identified in error after some providers appealed the findings. As an example, one provider appealed its findings of more than $2.5 million in overpayments. During the appeals process for this provider, HCPF concluded that most of these findings were not accurate and reversed its demand for repayment for all the findings that had been identified related to the policy change. This resulted in a settlement with the provider for a repayment of $60,000, which was for findings not related to the policy change.

Billing of Initial Inpatient Visits Audit Scenario. HCPF approved this automated audit scenario in May 2022, based on American Medical Association (AMA) CPT guidance, and the audit began in September 2022. According to our analysis of a HCPF report of claims audited, providers appealed about 58.5% of the findings from this audit and several providers we talked with during our evaluation mentioned this specific audit as one that has been problematic because the guidance HCPF issued for these services lacked clarity and specificity. In March 2010, HCPF advised providers in a bulletin that specific codes for office/outpatient consultations and for inpatient consultations could no longer be used and that other existing codes should be used for both outpatient and inpatient consultations. The bulletin did not specify what other codes would be appropriate for these services but did say that “This change is being implemented to be consistent with Medicare policy.” According to provider documents we reviewed, some providers interpreted this language to mean that, when they billed HCPF for outpatient and inpatient consultations, they should use codes established in Medicare policy. However, HCPF told us that was not the message the bulletin intended to communicate, and submitting claims to Medicaid for these consultations using Medicare codes was not compliant with HCPF’s billing requirements.

The audit identified almost 28,000 overpaid claims totaling about $1.7 million. According to information from HCPF, as of December 2023, no decision has been rendered on any of the appeals from this audit.

Why Did the Problem Occur?

Although HCPF has some policies and procedures related to the development and approval of RAC audit scenarios, we identified several areas where they could be strengthened. Specifically, HCPF's policies and procedures do not sufficiently:

- Define what HCPF divisions should be included in the review and approval of audit scenarios, or what the role and responsibilities of each division should be in the review process. For example, HCPF told us that when a scenario related to radiology services is developed, HCPF radiology, physician and hospital policy staff would be responsible to participate in the review and finalization of the radiology services scenario. However, there is no policy that documents this responsibility or outlines what the participation should entail.
- Identify the information each division needs to fulfill its responsibilities and establish processes for distributing the information to the divisions. From our review of these three scenarios, we noted that HCPF's program, benefits, and policy staff involved in the review and approval of audit scenarios did not receive complete information on the scenarios. For example, the emails sent to the Medicaid program/policy staff did not include the full detail included in the request HMS submitted to HCPF. Some of the missing details included references to policies, bulletins, impacted providers, and potential volume of claims with overpayments.
- 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.

Why Does This Problem Matter?

When HCPF and HMS do not thoroughly investigate the audit scenarios prior to an audit, there is a risk of inaccurate audit findings, which can create additional costs for providers and HCPF. For example, for the one provider discussed above that underwent the Level of Care audit and appealed the findings in 2022, both the provider and HCPF spent time and other resources over the course a year before finally settling the appeal and overturning nearly all the $2.5 million in findings because they were inaccurate.

Demanding repayment of overpayments that are identified through audits that apply incorrect or imprecise standards can also undermine HCPF's credibility with the provider community and is counter to the fundamental purpose of the RAC program, which is to improve program integrity.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

A. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. The Department will create a process where HCPF's Executive Leadership Team (ELT) approves all audit scenarios and will enhance clarity around the roles and responsibilities of each division.

Documents were provided that show the level of interaction department policy staff has with audit review, approvals, and clarifications. This includes all audit projects proposed as drafts with track changes, comments, and recommendations from policy staff. The emails for approval are the final assurance that we did validate the audits with that group. If the policy team finds subsequent, previously unpublished policy notices, that revise a subset of claims audited by the RAC, the RAC program staff at the Department and the RAC vendor immediately will cease auditing to clarify information or adjust the audit based on policy and Attorney General recommendations. These subsequent revisions do not invalidate previous audit findings but do require revisions for forward audit standards. This recommendation encompasses a review of 3 of 30 scenarios where policy was changed, rules were changed, or federal guidance was changed after the review was completed. This includes cases where litigation was active for years after the audit was conducted.

Addendum: This finding and recommendation do not address RAC audit scenarios "where policy was changed, rules were changed, or federal guidance was changed after the review was completed." For the scenarios discussed in the finding where outdated policies, rules, or guidance were applied, those changes occurred during the period covered by the RAC audit, not after the RAC audit was completed.

B. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. HCPF recognizes that it can enhance e-controls and is already working on a process to have the HCPF's ELT as well as the RAC provider advisory board review audits before final approval, have the documentation showing dated approvals from each policy staff area or office within the Department, and update the external communications to have better transparency with stakeholders.

C. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation.

There are currently controls in place and contract provisions that outline the quality metrics and remedies to follow when issues with an audit arise. There are also specific cases where evolving information necessitates a modernization of an audit. The current overall quality of the RAC reviews and adherence to timelines is strong; still, HCPF will review national standards, laws, and guidelines to enhance current processes.

The report indicates issues with three specific audits, out of an inventory of 30 audit versions. Also, we noticed that the sample size against a claim population of over 482,000 claims was far below the CMS-recommended 384 reviews across all of the scenarios to achieve 95% / 5% statistical sampling.

Addendum: This finding is based on in-depth review of materials related to the three RAC audit scenarios discussed, not on a sample of claims. Further, CMS does not recommend sample sizes for evaluations done by the OSA or its contractors.

Finding 2 – Application of Contingency Fee

State Medicaid RAC programs are intended to be fully funded by the recovery of the overpayments that the RAC vendors identify. Specifically, the RAC vendor fee must be paid out of recoveries, as indicated in 42 CFR § 455.510(b)(1). Recovering funds from a specific overpayment finding or group of findings can be a lengthy process. If providers request Informal Reconsiderations and/or appeals, it may take months or years to finalize the finding and collect overpayments.

According to 42 CFR §433.300(a), states must repay the federal share on the full identified overpayment amount, regardless of whether the states actually recover the full identified amount; 42 CFR §455.510(b)(1) requires states to pay their RAC vendors on amounts the states actually recover. CMS RAC FAQs published in 2011 include that a RAC contingency-based contract where the contractor is paid based on amounts recovered minimizes expenses compared to other payment methodologies.

What Work Was Performed, and What Was the Purpose?

We reviewed federal and state requirements related to paying the RAC and the terms in HCPF's 2016 and 2021 RAC contracts that outline how HMS will be compensated.

We also reviewed a series of emails between CMS and HCPF addressing a question from HCPF regarding whether the RAC contingency fee can be paid on uncollected overpayments from providers. The emails were dated between April 12, 2016, and June 10, 2016.

The purpose of this work was to evaluate HCPF's compliance with federal and state requirements related to paying the RAC.

How Were the Results of the Work Measured?

Federal and state regulations indicate that the contingency fee a state pays its Medicaid RAC vendor is to be based on the amount of overpayments recovered from providers. Specifically:

- Under federal regulations, "The contingency fees paid to Medicaid RACs must be based on a percentage of the overpayment recovered." [42 CFR 455.510(b)(1)]. In a series of emails between CMS and HCPF, CMS affirmed this expectation, stating: "The RAC final rule, PDF page 15, states that payments to RACs may not be made based on amounts merely identified but not recovered."
- Under state statute, HCPF is authorized to enter into a contract with a qualified agent to audit providers where the "compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider." Further, the "compensation paid to the contracting agent under a contingency-based contract shall not exceed 18% of the amount finally collected from the provider overpayment" and "In any contingency-based contract authorized pursuant to this paragraph (b), the state of Colorado shall not be obligated to pay the contracting agent for amounts not actually collected from the provider." [Section 25.5-4-301(3)(b), C.R.S.]

These legal requirements specify that the contingency rate be applied to the amount *recovered*—not the amount *identified* by the RAC as an overpayment. This distinction is important because providers can appeal identified overpayments and it is not uncommon for HCPF to enter into a settlement agreement with an appealing provider in which the provider repays only a portion of the amount identified.

What Problem Did the Work Identify and Why Did It Occur?

We found that HCPF's 2021 RAC contract contains a provision that is contrary to federal and state requirements that contingency payments be based solely on funds recovered from providers due to RAC audits. Specifically, Section 1.27.6 of the contract states,

> "In the event of settlement of claims during the appeal process, *where the settlement amount is less than the full findings* amount, *the State will pay Contractor the contingency fee associated with the full findings* unless it is determined that settlement occurred due to invalid findings by Contractor." *Emphasis added.*

HCPF confirmed that it pays HMS the contingency fee based on the full amount HMS identifies as overpayments, even when HCPF does not recover the full amount identified due to settlements. HCPF stated that it uses this payment approach because it fairly compensates HMS for the work done and does not penalize HMS when the state chooses to settle, which occurs frequently. HCPF could not explain how this payment approach is consistent with federal and state requirements.

Further, the 2021 RAC contract contains other provisions that appear to conflict with Section 1.27.6, stating that "Contractor will be paid … a contingency fee of the total dollar amount of overpayments *recovered and received* through Contactor's audits during the full Contract period," that the "contingency fees to be paid by the Department to Contractor for the Work are: (1) Contingency Fee Percentage Rate of 18% of recovered overpayments …" [Contract Sections 2.1.1.2 and 2.1.2.1]

Why Does This Problem Matter?

The HMS contract may not comply with federal regulations for contingency fees. Non-compliance with federal regulations could put the Colorado RAC program at risk for further scrutiny and corrective action from CMS. Corrective action plans are typically written by the State and approved by CMS. Corrective action plans provide information on how and when the State will implement changes to address deficiencies in the RAC program.

In addition, the practice of compensating the RAC for identified but unrecovered overpayments could provide an incentive for HMS to be overzealous in its audits. In any case where HCPF settles an appeal with a provider, there is no final determination of whether the findings were valid, because the cases do not go before an Administrative Law Judge. HCPF has stated that no appeals from 2018 through 2023 have been heard by an Administrative Law Judge. As a result, HCPF may settle with a provider on findings that were not valid, and pay HMS based on the identified overpayment amount. Alternatively, HCPF may settle an overpayment finding and

recover less than the full identified overpayment amount, but still pay HMS for the identified amount.

We were unable to match the amount of overpayments identified through RAC audits, the proportion of those identified that were not ultimately recovered, and the amounts HCPF paid HMS for the findings. This is because HCPF does not track total identified overpayments and the recoveries on such overpayments in any global manner. HCPF told us the amounts identified and recovered are tracked only on an appeal-by-appeal basis. Thus, although HCPF reported it recovered about $82 million in overpayments in Fiscal Years 2021 through 2023, HCPF could not tell us the amount of total overpayments identified that resulted in these recoveries or the amount it paid HMS for those identified overpayments.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

Agree

Implementation Date: 08/2024

The Department agrees 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.

Finding 3 – Use of Contract Transmittals

HCPF has established a practice of using "transmittals" to provide contractors with "official direction within the scope of the Contract." HCPF has issued nine transmittals related to the RAC program since it began contracting with HMS in 2016. Transmittals are used to clarify contract requirements, update deadlines, and provide detailed direction on how the contractor should comply with provisions in the contract.

What Work Was Performed, and What Was the Purpose?

We reviewed HCPF's 2016 and 2021 RAC contracts, Health Management Systems, Inc.'s (HMS') RAC Policies and Procedures Manual, and routine reports provided to HCPF by HMS. We also reviewed all of the transmittals HCPF has issued to HMS since HMS first became the RAC in 2016 and interviewed HCPF staff about the contract transmittal process.

The purpose of our work was to evaluate how HCPF uses transmittal letters and the role they play in HCPF's oversight and enforcement of the RAC contract.

How Were the Results of the Work Measured?

Language in HCPF's RAC contract indicates that transmittals are a critical part of the communication from HCPF to HMS and serve as official directives. For example, the contract states that the contractor "shall comply with all direction contained within a transmittal" and "shall retain all transmittals for reference." In addition, Section 1.8.5. of the contract directs HMS to ensure that all official direction is documented in a transmittal, stating that "if the Contractor receives direction from the Department outside of the transmittal process, it shall contact the Department's primary designee and have the Department confirm that direction through a transmittal prior to complying with that direction."

Section 1.8.2. of the contract states that for a transmittal to be considered complete, it must include, at a minimum, an effective date, direction to the contractor regarding performance under the Contract, and a due date or timeline by which Contractor shall comply with the direction contained in the transmittal.

Section 1.8.6. of the Contract states "Transmittals may not be used in place of an amendment, and may not, under any circumstances, be used to modify the term of the Contract or any compensation under the Contract."

What Problem Did the Work Identify?

We identified problems with how HCPF has used transmittals for the RAC contract. First, although the contract stipulates that transmittals may not, "under any circumstances" be used to modify the contractor's compensation, we found one transmittal did increase compensation to HMS without a contract amendment. On October 15, 2020, HCPF issued a transmittal to HMS that increased its contingency fee. HCPF told us that this decision was made by management to help address the emergency under the pandemic.

Under the 2016 RAC contract, which was still in effect in October 2020, the contractual contingency fee was tiered, with a maximum of 13.5% paid for automated audits and a maximum of 17% paid for complex audits. These maximums were paid if the contractor met all contractual performance measures. The October 2020 transmittal implemented a guaranteed 18% contingency fee for both automated and complex audits with a stipulation that the contractor would be subject to a corrective action plan if performance metrics were not met. It made the fee effective for automated audits that began on or after the date of the transmittal and made it retroactive for complex audits that began no earlier than July 2020. (Contract Transmittal #5; October 15, 2020).

Second, we found that six of the nine (67%) transmittals that HCPF issued to HMS for the RAC program since 2016 were prepared and communicated before the 2021 contract was executed. Although HCPF told us it expects HMS to continue adhering to these six transmittals, it did not update or reissue them after executing the 2021 contract with HMS and all the transmittals include references to specific sections of the 2016 contract, which is no longer in effect.

Third, there is a lack of consistency in HCPF's use of transmittals to provide direction to HMS. The transmittals that have been issued address items that appear to vary in importance, ranging from defining the Department's "business day" (Contract Transmittal #3; September 11, 2018) to establishing limits on the number of claims HMS can audit each year (Contract Transmittal #2; February 1, 2018). In contrast, we identified two instances of HCPF providing direction to HMS about compliance with provisions in the RAC contract without using a transmittal, as described below.

- **Audit Project Plan**. The 2021 RAC contract requires HMS to prepare a two-year Audit Project Plan that contains a variety of information including a list of approved audit scenarios, methods for conducting outreach and education to providers, and projected audit start and completion dates. However, HCPF told us that the requirement was only applicable to the 2016 contract because, when HMS first became the RAC, HCPF wanted an initial two-year start-up plan. HCPF told us that it validates that the requirements were met through communications with HMS including periodic reporting, division-wide audit plans, and emails that provide a more fluid method of planning and oversight of audits than a single document. From our review, it appears that the critical components of an Audit Project Plan, as outlined in the contract, are encompassed in other documents and reports. HCPF stated that it retained the requirement for the two-year plan in the 2021 contract in case it decided it wanted such a plan in the future. HCPF did not issue a transmittal to HMS to communicate that the plan was not required.
- **Underpayment Reporting.** The 2021 RAC contract includes a requirement for HMS to report the number and amount of any provider underpayments identified during the audit process and include a list of such underpayments in monthly status reports submitted to HCPF. An underpayment occurs when the provider's payment is less than what is supported by the provided documentation and the Medicaid allowed amount for the service provided. We reviewed the monthly reports for a four-year period and found no discussion of underpayments. According to HCPF, it told HMS it did not need to prepare monthly reports for underpayments because HMS notifies HCPF immediately on the rare

occasions it finds an underpayment. HCPF told us that only 26 underpayments were identified by HMS during audits from 2018 through 2023. HMS does not specifically audit for underpayments to providers because this is not a federal requirement, and the RAC contract does not require such audits and does not compensate for finding underpayments. HCPF did not issue a transmittal to HMS to direct it to discontinue any monthly reporting on underpayments.

Why Did the Problem Occur?

We found that HCPF has not fully defined the use of transmittals for the RAC program. First, although the contract appears to intend for transmittals to serve as formal and official means for HCPF to provide guidance to HMS, it does not outline when other forms of communication will suffice. For example, the contract requires HMS to (1) comply with all direction contained within a transmittal, (2) contact the Department to obtain direction if the contractor receives conflicting transmittals, (3) contact the Department to obtain a transmittal prior to complying with any direction provided by the Department outside of the transmittal process, and (4) retain all transmittals for reference [Contract Sections 1.8.2, 1.8.4, 1.8.5, and 1.8.7]. The contract also stipulates that "Transmittals may not be used in place of an amendment, and may not, under any circumstances be used to modify the term of the Contract or any compensation under the Contract." [Contract Section 1.8.6]. These requirements appear to indicate the importance of using transmittals for official direction and provide specific instances when they cannot be used. However, in contrast to these precise directives, the contract also states that transmittals "are not intended to be the sole means of communication between the Department and Contractor, and the Department may provide day-to-day communication to Contractor without using a transmittal." [Contract Section 1.8.6]. The contract does not define or provide examples of the kinds of communication that do not require the use of a transmittal.

Second, HCPF has no written policies or procedures to guide staff on the proper use of transmittals.

Why Does This Problem Matter?

Given the extent of the contract language related to transmittals and the requirements for HMS to comply with them, and the lack of direction in the contract about what kinds of information should be provided through other means, there is a risk that HMS will consider any direction from HCPF that is not contained in a transmittal to be optional. Similarly, not renewing or updating old transmittals may cause HMS to disregard them since they refer to an expired contract and transmittals may not, in fact, be binding on HMS.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

A. **Agree**

Implementation Date: 08/2024

The Department agrees with this recommendation. HCPF will ensure that the RAC program follows the Department's Standard Operating Procedures for amending contracts and payments through the required eClearance process approved by and executed by the Executive Director.

B. **Agree**

Implementation Date: 08/2024

The Department agrees with this recommendation. We do have Department guidance, training, and policies. We are drafting additional RAC contract-specific guidance to ensure that documentation gives clear procedures and rules related to the use of transmittals.

C. **Agree**

Implementation Date: 08/2024

The Department agrees with this recommendation and will ensure consistent use of contract transmittals by implementing written policies and procedures that require transmittals to be updated or reissued if upon contract expiration the information therein is still relevant.

Finding 4 – Monitoring of HMS Staff Credentials

Federal regulations require that RACs have the technical capability to carry out the activities of the RAC program and indicate that such technical capability is provided, in part, through "the employment of trained medical professionals […] to review Medicaid claims." The regulations do not prescribe the qualifications or number of staff a RAC must employ other than requiring that a licensed and experienced Doctor of Medicine or Osteopathy be on staff to serve as the RAC's medical director [42 CFR §455.508]. Therefore, states have the authority to establish the specific requirements their RAC contractors must meet in terms of the qualifications and responsibilities of the contractor's reviewers. HCPF's RAC contract includes requirements for its current RAC contractor, HMS, to employ licensed medical professionals and certified medical coders and assign them to RAC audits. A certified medical coder is a highly qualified health care professional who translates medical diagnoses, procedures, services, and equipment into medical codes so that claims can be billed or filed with insurance, Medicaid, or Medicare accurately and consistently. The Certified Professional Coder (CPC) certificate, offered through the American Academy of Professional Coders, is a nationally recognized standard in medical coding. However, there are other certifications that are also accepted, including The American Health Information Management Association (AHIMA) certification.

HMS is accredited by the Utilization Review Accreditation Commission (URAC), a non-profit accreditation entity. According to the URAC website, one aspect of awarding accreditation to an organization is an assessment of that organization's reviewer qualifications to provide assurance that review staff maintain current licenses and credentials. Accreditation expires after three years unless it is renewed by the accredited entity.

RAC audits are divided into two types: complex and automated. In a complex audit, medical records are reviewed by clinically licensed staff to determine if payments were proper and there may be several reviews of medical records by RAC staff. Claims found to be improper upon initial review undergo a secondary review by another licensed medical professional to confirm the finding. In addition, if a provider requests an Informal Reconsideration or appeals a finding, a physician is required to review the medical records to decide whether to uphold or withdraw the finding.

Automated audits rely on electronic data analysis to identify improper payments. Automated reviews involve analysis of claims data to identify overpayments based on medical coding and billing policies. Although an automated audit typically does not involve review of medical records to identify findings, as with complex audits, when a finding from an automated audit is involved in an Informal Reconsideration all medical records are required to be reviewed by the appropriate clinical professional, which could be a nurse, coder, or physician. In the case of an appeal, the medical records for the finding are required to be reviewed by a physician.

What Work Was Performed and What Was the Purpose?

At the beginning of our review, we requested from HCPF the job descriptions, summaries of experience and education, and copies of the licenses and certifications of the HMS staff members involved in reviewing medical claims for RAC audits.

In response to our request, we ultimately received information from HCPF that identified 61 unique HMS clinical staff assigned to work on RAC audits. The information was provided as follows:

- In mid-September 2023, HCPF provided 24 resumes of HMS staff who worked on RAC audits. Since 4 of the 24 resumes were for HMS staff whose positions did not require license or certification, there were 20 HMS staff who held positions that required professional medical license or certified medical coding credentials. HCPF did not provide copies of professional medical licenses or certified medical coding credentials for these 20 HMS staff.
- In early December 2023, HCPF provided a list of 42 HMS staff who worked on RAC audits, without including copies of professional medical licenses or certified medical coding credentials. However, HCPF included the job descriptions of these staff, which required a certain license or credential applicable for each position. Two individuals on this list were included in the previously received 24 resumes; therefore, this list added 40 HMS staff who worked on RAC audits and held positions that required professional medical license or certified medical coding credentials.
- In April 2024, HCPF provided copies of 25 medical licenses and one medical coding certification for HMS staff that worked on RAC audits. These included credentials for 25 of the individuals in the previously received resumes and list plus one additional HMS staff who worked on RAC audits and held a position that required a medical license.
- On May 10, 2024, HCPF provided a screenshot showing that HMS is accredited by URAC through May 1, 2027.

Since we were not provided the requested copies of licenses and certifications until April 2024, we first conducted online research for the 20 staff whose resumes we received in September to try to confirm if their licenses and certifications were current. For physicians and nurses, we searched state regulatory agency websites; for medical coding staff, we attempted to verify current certification status on the website of the American Academy of Professional Coders (AAPC), however, we did not have sufficient information to complete our research. Therefore, we were able to independently verify the required credentials for 15 out of the 20 HMS staff whose resumes we received.

The 25 medical licenses and one coding certification HCPF provided us in April 2024, consisted of 11 credentials that we had already verified ourselves and 15 we had not found through our online research. Therefore, out of the 61 HMS staff HCPF identified for us that work on RAC audits, we obtained verification that 30 had current credentials at the time of our evaluation. We were unable to verify the credentials of the other 31 staff.

The purpose of our work was to assess if HCPF monitors HMS staff working on RAC audits to ensure required professional medical licenses or certified medical coding credentials are maintained by HMS staff who conduct the audits, including reviewing medical records, identifying overpayments, validating findings, and making determinations when findings undergo an Informal Reconsideration or are involved in an appeal, as required in the RAC contract.

How Were the Results of the Work Measured?

HCPF has established requirements for RAC staff to have appropriate training and experience to review claims, in accordance with federal regulations. In general terms, HCPF's RAC contract requires HMS to (1) employ a medical director who has the qualifications and experience outlined in federal regulations, and (2) use "appropriately licensed, experienced health care professionals [during RAC audits] to pre-screen and make initial case review findings." The contract more specifically states that, for staff who review claims during a RAC audit, HMS must:

- "… peer-match case reviewers to the kind of Provider being reviewed (i.e. doctors will review doctors; dentists will review dentists, etc.)." [Contract Section 2.4.3.7.3.]
- use only "experienced and appropriately certified professional claims coding specialists to review provider coding." [Contract Section 2.4.3.7.6].

In August 2020, HCPF issued a contract "transmittal" to HMS to provide clarification on these requirements. HCPF issues transmittals to provide official direction within the scope of a contract. This transmittal included specific direction that:

- Coding findings must be reviewed and verified by professional certified coders. Coding findings are overpayments identified as a result of improper coding of a claim, such as using unauthorized coding.
- A physician is not required to conduct an initial review of all claims but is required to review findings, whether identified through complex or automated audit, during Informal Reconsiderations or appeals.

Further, the RAC contract requires that HMS provide HCPF with certain details about the staff assigned to the contract, including a list of such staff and copies of professional licenses or certifications held by those staff, if licensing or certification is part of their job requirements. HMS must also provide HCPF with copies of new and renewed licenses or certifications as they occur. The following language is included in HCPF's 2022 RAC contract:

2.1.6. If any of Contractor's Key Personnel and Other Personnel are required to have and maintain any professional licensure or certification issued by any federal, state or local government agency, then Contractor shall submit copies of such current licenses and certifications to the Department.

2.1.6.1. DELIVERABLE: All current professional licensure and certification documentation as specified for Key Personnel or Other Personnel

2.1.6.2. DUE: Within five Business Days of receipt of updated licensure or upon request by the Department

What Problem Did the Work Identify?

Although HCPF told us it uses URAC accreditation to verify HMS staff's credentials, HCPF has not established sufficient processes to monitor HMS to ensure that HMS staff conducting RAC audits have the qualifications and experience required by the RAC contract.

Based on our review, we concluded that HMS does employ a medical director who has the qualifications and experience outlined in federal regulations and the RAC contract. However, although the RAC contract requires HMS to provide HCPF with the licenses and certifications held by HMS staff assigned to the contract, HCPF was not able to provide verification of current licenses or certifications for 31 out of the 61 HMS staff (51%) whose names HCPF supplied to us.

The information HCPF provided us about HMS staff was incomplete and disjointed; none of the information supplied by HCPF could be fully reconciled. Specifically:

- The information provided in September 2023 was for 20 HMS staff who worked on RAC audits and whose jobs required professional medical licenses or certified medical coding credentials.
- The information provided in December 2023 was for 40 additional HMS staff who worked on RAC audits and whose job responsibilities required current nursing licenses and/or coding certifications, although the list did not specify what license or certification each individual held.
- The credentials provided in April 2024 were for two additional HMS staff and 22 HMS staff that HCPF had already informed us of.

Due to the incomplete information in the list, and the disconnect between the list and the resumes, we were unable to verify whether all 61 staff were currently assigned to work on RAC audits or what their exact job duties were.

Why Did the Problem Occur?

According to HCPF, Section 2.4 of the 2022 RAC contract outlines that HMS has the responsibility to ensure it is hiring qualified staff to review claims data or medical documentation.

In addition, to reinforce this responsibility, HCPF has provided a desk procedure manual and the Colorado RAC policies and procedures documents to HMS, all of which discuss the licensing and certification requirements for HMS staff who review medical records, claims data, and other documentation submitted by providers. Further, HCPF told us it relies on HMS' certification by URAC for assurance that HMS staff working on RAC audits are properly credentialed. For these reasons, HCPF has not required HMS to provide routine staffing updates, including licensing and certification documentation.

There is a disconnect between HCPF's described method of verifying that HMS assigns qualified staff to RAC audits and the provisions of the RAC contract. Although HCPF told us it relies on HMS' URAC accreditation for this purpose, requirements in the RAC contract indicate that HCPF expects HMS to provide documentation that would allow HCPF to directly verify HMS staff qualifications. Further, the contract does not require HMS to maintain URAC accreditation or indicate that such accreditation will serve to assure HCPF that HMS staff assigned to RAC audits are qualified for their work.

Why Does This Problem Matter?

It is important that HCPF adequately monitor to ensure that HMS staff who are conducting claims reviews have the necessary qualifications and experience, and that HMS is complying with RAC contract requirements. 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.

Recommendation No. 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 URAC and to require the RAC to provide evidence of ongoing accreditation.

Response

Department of Health Care Policy & Financing

Agree

Implementation Date: 09/2024

The Department provided the auditors with the URAC certification for HMS, including third-party validation from the URAC website proving HMS certification. URAC is the nation's leading accreditation organization for pre- and post-utilization review organizations, like HMS. URAC verifies an organization's processes and procedures to ensure that the organization is operating at the highest standards, including personnel qualifications; specifically, this accreditation by URAC reflects compliance with the highest national review standards, assuring full faith and confidence that the HCPF RAC vendor that reviews claims comply with those high industry standards.

The Department will update its contract to require URAC certification, as a reflection of the proper credentials and processes, versus collecting and maintaining resumes on every

vendor employee. The Department will maintain a tracking mechanism that ensures the credentials of the contractually defined Key Personnel and consistent achievement of URAC accreditation of its RAC vendor through the life of the contract, reflecting the highest national standards of industry operations. The Department will also work with the CMS to institute an updated SPA with definitive criteria that follow national requirements outlined by the federal government that funds the RAC program for Colorado Medicaid. Any contractual reporting will be updated via transmittals to ensure clarity in the standards for both the State and the vendor.

The Department keeps all key personnel resumes, certifications, and licenses and verifies them. We also will be using the URAC accreditation to avoid claim-by-claim reporting and verification of each reviewer, which is not a feasible standard to institute. URA also avoids the need for HCPF is to verify each resume of each reviewer, which is beyond the scope of normal processes.

Addendum: Although HCPF provided the URAC certification for HMS, as stated in the finding, HCPF did not provide the credentials for some of the HMS personnel who were required to have them, which is required in the RAC contract.

Finding 5 – Mitigation of the Appearance of a Conflict of Interest

HCPF contracts with a variety of vendors to provide Medicaid program services and support. One of these vendors is Gainwell Technologies, which serves as HCPF's fiscal agent for Medicaid, operating the State-owned Medicaid Management Information System (MMIS). Gainwell's responsibilities include, but are not limited to, the following:

- Processing and paying Fee-For-Service (FFS) provider claims
- Answering provider billing questions
- Assisting providers in the Medicaid enrollment process

HCPF has contracted with Gainwell Technologies for these services since at least 2016.

In December 2020, HMS publically announced that HMS and Gainwell Technologies had reached a definitive agreement for Gainwell to purchase HMS. In April 2021, Gainwell Acquisition Corporation, the parent company of Gainwell Technologies, announced that it had acquired HMS. HCPF has contracted with HMS for RAC audit services since 2016. Thus, since April 2021, both the processing of claims payments and the auditing of provider billings has been conducted by private sector entities that are part of a single corporation – Gainwell Acquisition Corporation.

What Work Was Performed, and What Was the Purpose?

We reviewed HCPF's 2016 and 2021 RAC contracts with HMS, interviewed HCPF and HMS staff regarding Gainwell Acquisition Corporation's purchase of HMS, and reviewed HCPF emails from 2020 and 2021 regarding Gainwell's acquisition of HMS as well as HCPF documents from 2024 related to possible conflicts due to the acquisition. We also reviewed the RAC Program FAQs that CMS published in 2011 to address states' questions regarding Medicaid RAC programs, including questions and answers related to conflicts of interest.

The purpose of the work was to determine if HMS and Gainwell Technologies provided required disclosures to HCPF related to any actual or apparent conflicts of interest that might exist because of Gainwell Acquisition Corporation owning both Gainwell Technologies and HMS. We did not evaluate whether an actual conflict of interest exists as a result of the acquisition.

How Were the Results of the Work Measured?

CMS' FAQs for Medicaid RAC programs, issued in 2011, states that CMS sees an inherent conflict of interest when a state contracts with the same entity to provide both fiscal agent and RAC services. Specifically, CMS FAQs stated:

> Q24: Can fiscal agents or MMIS vendors perform the identification and recovery work associated with the Medicaid RAC program while simultaneously serving in the capacity of the respective State's fiscal agent or MMIS vendor?

A24: CMS believes that there is an inherent conflict of interest if the same entity simultaneously acts as both a Fiscal Agent or Medicaid Management Information System vendor and a Medicaid RAC in the same State. We believe that states should be cognizant of potential organizational conflicts of interest and *should take affirmative steps to identify and prevent any conflicts of interest*. *(Emphasis added)*

HCPF's RAC contract with HMS includes the following conflict of interest provisions:

- Contractor shall not engage in any business or activities or maintain any relationships that conflict in any way with the full performance of the obligations of Contractor under this Contract. [Contract Section 9A]

- Contractor acknowledges that, with respect to this Contract, even the appearance of a conflict of interest shall be harmful to the State's interests. Absent the State's prior written approval, Contractor shall refrain from any practices, activities or relationships that reasonably appear to be in conflict with the full performance of Contractor's obligations under this Contract. [Contract Section 9B]

- If a conflict or the appearance of a conflict arises, or if Contractor is uncertain whether a conflict or the appearance of a conflict has arisen, Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration. Failure to promptly submit a disclosure statement or to follow the State's direction in regard to the actual or apparent conflict constitutes a breach of this Contract. [Contract Section 9C]

What Problem Did the Work Identify and Why Did it Occur?

HCPF received an email from HMS in December 2020, notifying HCPF that an agreement had been reached for Gainwell Technologies to acquire HMS. However, between 2021 when Gainwell Technologies acquired HMS, and early 2024, HMS did not provide HCPF with a conflict-of-interest disclosure related to its purchase by Gainwell Technologies. The email notifying HCPF that Gainwell Technologies had acquired HMS did not include information on how operations would be managed to ensure that an actual conflict of interest would not occur. HCPF explained to us that it did not ask for additional disclosures because of the following:

1. HCPF does not require contractors to notify it in the event of a purchase, merger, or other change in legal or financial relationships during the contract term.

2. HCPF did not consider it to create a conflict of interest, in part because it does not view Gainwell Technologies and HMS as being the "same entity," as intended by CMS guidance. However, HCPF did not have disclosures about the potential for a conflict of interest due to the purchase or documentation that it thoroughly assessed the relationship for actual or perceived conflicts of interest.

3. Since Colorado's MMIS system is owned by the State and decisions regarding which edits are applied in the MMIS are controlled by the Department, not Gainwell, HCPF did not believe that an actual or perceived conflict of interest existed. In addition, HMS would not conduct any audits or reviews on Gainwell Technologies, the State's fiscal agent.

4. HCPF reported to us there is no interaction between HMS' RAC staff and Gainwell Technologies' fiscal agent staff.

In response to our inquiries, in February 2024, HCPF obtained a statement from HMS about its conflict of interest practices, which included the following:

- HMS is a legal entity separate and distinct from its affiliate, Gainwell Technologies LLC. The parent company of both entities is Gainwell Acquisition Corporation. This corporate structure maintains the separation between HMS and Gainwell.
- HMS maintains entirely separate employees, platforms, processes, procedures, and systems to operate its RAC contracts from those of Gainwell. HMS interfaces with Colorado's MMIS system, operated by Gainwell, in a manner that is no different than with any other MMIS vendor for any state; such interfaces do not present a conflict of interest but rather are an operational function where multiple entities are contracted by the same State. Only those HMS employees who support the Colorado RAC contract have access to RAC data.
- HMS is focused on preventing conflicts of interest related to its RAC work given the affiliation with Gainwell and, for that reason, has taken extensive steps to ensure that no conflict exists.
- HMS is fully compliant with its contractual obligations including the conflict-of-interest disclosure requirements.

According to HCPF, this statement is not the disclosure required in the contract, but it explains all the relevant details of the relationship between HMS and Gainwell Technologies and supports HCPF's stance that no actual conflict exists. However, this statement was not provided until almost three years after Gainwell Acquisition Corporation purchased HMS, and only due to the questions we raised in this evaluation.

Why Does this Problem Matter?

HCPF's RAC contract with HMS includes the following provision, "even the appearance of a conflict of interest shall be harmful to the State's interests." Based on comments made by some providers during our interviews and surveys, it appears there may be some questions about the relationship between HMS and Gainwell Technologies. For example, we found there is an appearance of a conflict, at least among some Colorado Medicaid providers that responded to our survey and participated in interviews with us.

In interviews and survey responses, some providers referred to the RAC vendor as "Gainwell" or "Gainwell/HMS," indicating that the distinction between the RAC and the fiscal agent is unclear to these providers.

The potential appearance of a conflict of interest between HMS and Gainwell could also be caused by the following:

- Communications from HMS employees to providers are delivered from a Gainwell email account.

- HMS uses Gainwell branding in some cases. For example, HCPF maintains a RAC program webpage with a link to HMS. Clicking the link opens a webpage that has an HMS logo and contains information specific to Colorado's RAC program (https://resources.hms.com/state/colorado/rac). Clicking on the HMS logo at the top of this page leads the viewer to the Gainwell Technologies homepage. Also, typing "hms.com" into the address bar of a web browser opens the Gainwell Technologies homepage.
- One of the monthly status reports HMS submitted to HCPF, in May 2023, used Gainwell branding only; HMS is not mentioned. In addition, the HMS employee who manages the Colorado RAC contract is identified in the monthly status report as working for Gainwell Technologies with a Gainwell email address. All the other monthly status reports, prior to May 2023, we reviewed used HMS branding.
- Since Gainwell purchased HMS almost three years ago, HCPF has not issued any communications to the provider community, such as bulletins or newsletters, to reassure providers that HCPF has assessed the situation and determined that there is no conflict. HCPF also has not given the provider community an explanation of any controls that Gainwell, HMS, and HCPF, have established to prevent a conflict of interest.

We could not determine, from our survey or interviews, whether the perception of the RAC and the fiscal agent being the same entity is pervasive throughout the Medicaid provider community. According to HCPF, providers have not indicated any concerns that they have related to a conflict of interest between HMS and Gainwell. However, the information we obtained during the evaluation, indicates that there may be some questions among providers about the relationship. Therefore, it is important that HCPF clarify to providers the steps that it has taken to ensure that there is not a conflict of interest.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

A. **Disagree**

The Department disagrees with this recommendation. U.S. Securities and Exchange Commission (SEC) filings, communications of the review, and other documentation were supplied showing that HCPF knew about the acquisition far in advance and that the conflict did not exist. The Department further clarified that the RAC FAQ from 2011 gives guidance for when a claims system and a RAC are owned by the same entity there should be a thorough review, however, the documentation supplied shows that HMS and Gainwell are completely separate entities with their own CEOs, and staffing.

Unlike other states, the processing of provider payments and MMIS edits are completely controlled by the Department, which owns the payment system. Further, the Department controls all the edits and approvals in the claims system. HMS does not review claims system controls but rather reviews the actual submitted claims information from providers. In no way does HMS have any control or influence over the claims system.

Addendum: As noted in the finding, the RAC contract states: "Contractor acknowledges that, with respect to this Contract, even the appearance of a conflict of interest shall be harmful to the State's interests" and "If a conflict or the appearance of a conflict arises …Contractor shall submit to the State a disclosure statement setting forth the relevant details for the State's consideration". [Contract Sections 9B and 9C]. The documentation provided by HCPF did not address the appearance of a conflict of interest and how HCPF ensured that a conflict of interest did not exist.

B. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. The Department can agree that we will update policies and procedures and strengthen the process using state and federal laws and guidance.

In our contracts, we do now have provisions that ensure when there is a purchase, merger, or change in ownership that the contractor does report this change in advance. However, the report indicates that we did not know in advance that this transaction was happening. We believe we were aware and that this was substantiated in the communications and documents provided.

Addendum: The focus of this finding is on HCPF establishing controls to require contractors to provide notice if they are involved in purchases, mergers, or other changes in legal or financial relationships during a contract. As of the time we completed work on the evaluation, in mid-May 2024, HCPF had not provided documentation that it had amended the RAC contract to require such notice.

C. **Agree**

Implementation Date: 10/2024

The Department agrees with this recommendation. As noted in the previous recommendations, HCPF reviewed to ensure there was no conflict in advance of the merger. We are willing to document and publish the oversight and define the roles of both HMS and Gainwell to ensure there is clarity in those roles.

D. **Agree**

Implementation Date: The Department did not provide an implementation date.

The Department can continue to provide clarification of roles and responsibilities between Gainwell and HMS to our provider partners and other stakeholders, as indicated above.

Addendum: The response does not address the concern of HMS communicating with the Medicaid provider community using Gainwell email addresses or preparing documents related to its RAC function that use Gainwell branding.

Policy Consideration A – Medicaid RAC Federal Regulation Flexibilities

Statute required us to "assess federal flexibilities pursuant to 42 CFR 455.516 that Colorado can utilize in order to improve the RAC program and assist in pursuing those flexibilities, when already authorized [including] provider education, training, and error rates" and "the timing and procedure [for] assessing when a potential overpayment is "identified."" [Sections 25.5-4-301(3.7)(b)(I), (b)(II)(E), and (b)(II)(C).]

We reviewed Medicaid RAC federal regulations to assess program flexibilities and exceptions offered to the states. States have considerable flexibility regarding the design, procurement, and operation of their respective RAC programs, including the ability to:

- Establish the compensation structure for the identification of underpayments.
- Define the state's appeals process.
- Exclude claims from Medicaid RAC review.
- Coordinate the collection of overpayments (how and when overpayments are collected).
- Set contingency fee rates.

The states can also request exceptions from some of the key CMS requirements via a State Plan Amendment (SPA):

- To exceed the maximum RAC contingency rate established by CMS.
- To implement a longer lookback period than the three-year standard established by CMS.
- To allow the RAC vendor to hire less than the 1.0 FTE Medical Director required by CMS.
- To not implement a RAC program at all if the state's law prevents the state from following key federal requirements.

HCPF has exercised these flexibilities and exceptions, including setting a contingency rate above the rate established by CMS, using a seven-year lookback period instead of the three years set by CMS, and requiring HMS to employ a 0.1 FTE medical director instead of a 1.0 FTE medical director. CMS has approved all of the Colorado requested exceptions.

Through interviews with other states' RAC programs and review of other states' RAC program documentation, we found that each state uses flexibilities and exceptions in the Medicaid RAC program based on its individual needs and state laws. Although we did not identify features or practices of other states' RAC programs that are clearly more advantageous than Colorado's, in our evaluation we have noted differences between how Colorado and other states use the flexibilities offered in federal regulations. These include:

- The contingency fee rate, as discussed in Policy Consideration H.
- The lookback period, as discussed in Policy Considerations D and E.
- Paying the RAC to identify underpayments, as discussed in Policy Consideration H.

Policy Consideration – We do not provide an overall suggestion on implementing these federal flexibilities, which are policy decisions for Department of Health Care Policy & Financing and the General Assembly, and may require guidance from CMS.

Policy Consideration B – State Flexibilities to Resolve Overpayment Findings and Improve Provider Accountability

As part of our review of methods that Colorado could use to improve its RAC program, we assessed processes for providers to contest RAC audit findings and for HCPF to identify and address the causes of provider overpayments. We interviewed HCPF staff and reviewed HCPF data to understand how providers participate in the audit and appeals processes. We also interviewed staff from the Attorney General's Office, which represents HCPF when a provider formally appeals RAC findings.

The RAC program has been set up so that providers have a voice to express any concerns they have with the RAC findings that identify overpayments. For example, when HMS identifies potential overpayments during an audit, the associated provider has an opportunity to send HMS medical documentation to support the services they provided and the amounts they billed for those services. For complex audits, HMS also gives providers the opportunity to request and participate in an exit conference to discuss the findings and any concerns.

According to HCPF, for complex audits, the provider has 10 days from the date that HMS requests medical records for the audited claims to request that HMS schedule an exit conference. During the exit conference, HMS meets with the provider to discuss clinical opinions related to the questioned claims in the audit findings, and the provider is given time to send HMS additional documentation, which can result in HMS overturning or eliminating findings based on the additional information received. HCPF and HMS do not offer exit conferences for automated audits.

Regardless of whether a provider participates in the audit exit conference process the provider may contest the audit findings by using two options— (1) Colorado statute and regulations allows providers to file a request for Informal Reconsideration, and (2) Colorado statute and regulations allow providers to file an appeal with the Office of Administrative Courts. An Informal Reconsideration is an administrative process that allows a provider time to contest the findings, and for HMS and HCPF to review additional provider documentation and determine whether to maintain or reverse the findings. The provider can choose to accept the Informal Reconsideration Determination or can appeal the decision to the Office of Administrative Courts. The benefit of the Informal Reconsideration process is that it can resolve findings without progressing through the court hearing process.

If the provider contests the Informal Reconsideration Determination, or chooses to bypass the Informal Reconsideration process and file an appeal directly with the Office of Administrative Courts, the provider must send a prehearing statement and evidence to support its case, such as medical documentation, to the Office of Administrative Courts, HMS, and HCPF. Providers are not required to include the prehearing statement and evidence with their appeal, but must provide them 30 days prior to the hearing (OAC 1 CCR 104-1, Rule 8). According to HCPF, this short time frame can limit its and HMS' ability to review the evidence prior to the hearing. As part of the appeals process, there is also a mandatory settlement conference among attorneys

for HMS, HCPF, and the provider, during which the parties discuss and potentially compromise on the terms of a settlement, such as the amount of repayment that the provider owes or the specific services in question. If no settlement is reached, then the case progresses in accordance with the Colorado Administrative Procedure Act [Section 24-4-101 et seq., C.R.S], and there is a hearing and decision by an Administrative Law Judge (ALJ).

According to HCPF, some providers routinely contest RAC audit findings, often bypass audit exit conferences and the Informal Reconsideration process, and choose to file an appeal. For example, **Exhibit 8** shows a snapshot of appeals for three large providers that operate a total of 40 hospitals and health care facilities in Colorado. The data, which were provided by HCPF, show that these three providers filed appeals on 4,641 RAC audit findings, along with data on the Informal Reconsiderations and exit conferences that preceded the appeals.

Exhibit 8: Examples of Exit Conference Participation, Informal Reconsiderations, and Appeals by Three Large Providers in Colorado

Provider and Count of Facility Locations Involved in These Audits	Claims that Provider Requested to Discuss in Audit Exit Conferences	Claims with Findings After the Audit Exit Conference[1]	Informal Reconsiderations Submitted By The Providers For These Claims	Findings Overturned During Informal Reconsiderations Based on New Information from Providers	Findings Upheld by HMS/HCPF Informal Reconsiderations	Appeals Filed By The Providers Without Informal Reconsiderations For These Claims	Appeals Filed After Informal Reconsiderations For These Claims
Provider #1, 5 facilities	5,317	2,755	840	174	666	554	680
Provider #2, 4 facilities	7	3,448	669	240	429	796	424
Provider #3, 16 facilities	72	8,323	5,554	1,264	4,290	11	3,537
Totals	5,396	14,526	7,063	1,678	5,385	1,361	4,641

Source: HCPF provided data.
1 – For Providers 2 and 3, the number of Claims with Findings After the Exit Conference are higher than the Claims Requested to Discuss in Exit Conference because Providers 2 and 3 did not request exit conferences for the majority of their findings.

HCPF also provided the data in **Exhibit 9** showing increased appeals over recent years, by the same three large providers.

Exhibit 9: Appeals by Three Large Providers that Operate 40 Facilities in Colorado

Year	Number of Hospital/Facility Locations[1] That Filed Appeals Annually	Number of RAC Finding Letters	Number of Claims in RAC Finding Letters	Number of Claims Appealed	Appeal Rate
2019	6	6	134	56	42%
2020	3	2	91	54	59%
2021	14	24	983	809	82%
2022	24	127	4,401	4,231	96%

Source: HCPF provided data.
1 – Out of a total of 40 hospitals and health care facilities operated by the three large providers for which HCPF provided data.

According to HCPF, when providers contest RAC audit findings by choosing to file an appeal, rather than participating in the audit exit conference and the Informal Reconsideration process, they may not provide HMS and HCPF timely information on their concerns with the findings. According to the Attorney General's Office, the State may decide to settle appeals instead of proceeding to a hearing with an ALJ, which may result in overpayments that are not repaid to the State. In addition, the appeals process typically involves more resources for attorneys and staff time for all parties.

We identified the following gaps in HCPF's RAC program, with respect to statutory or regulatory requirements for providers to comply with best practices for resolving RAC findings:

- Providers are not required to exhaust the preliminary administrative process to contest the findings before filing an appeal. They are not required to request and attend the audit exit conferences to discuss their concerns or participate in the Informal Reconsideration process to provide documentation to support their position.

- According to HCPF, providers are not required to provide HMS and HCPF with documentation to support an appeal within a time frame that would allow HMS and HCPF to reasonably review and respond to the appeal prior to settlement.

- Providers are not required to provide HMS and HCPF an explanation of the basis of their appeal. According to HCPF, providers can appeal based on an argument that the findings are arbitrary or capricious without providing explanation of the argument or support to show that the RAC findings are inaccurate.

  HCPF reported that it does not have the statutory authority to require providers to address the causes of ongoing or repeated billing errors or improper billing, which can result in providers having RAC findings for consecutive years. For example, according to HCPF, settlement agreements cannot require the provider to take corrective action, such as attending additional training, to improve their billing compliance.

We identified five other states that have established these types of requirements in their statutes or Medicaid regulations to help resolve findings that the state identifies through Medicaid audits. For example:

- **Ohio, Texas, and Virginia require providers to exhaust the preliminary administrative process to contest findings before filing an appeal.** Ohio regulations state that a provider must "first [request] an informal review" of any preliminary adverse determination; if the provider does not agree with the informal review decision, they may request reconsideration; and they may only externally appeal the reconsideration decision with a court [Ohio Admin. Code 5160-57-04(B)]. Texas regulations specify that, after the provider exhausts the administrative process (i.e., the exit conference and Informal Reconsiderations process), they may appeal only if they send the state evidence of the dispositions from that administrative process [1 Tex. Admin. Code § 354.2217]. Virginia regulations state that the "internal reconsideration process is a prerequisite to filing for an external appeal" [12 Va. Admin. Code § 30-120-690(A)].

- **Illinois, New York, Ohio, and Texas require providers to submit documentation and support for the basis of their requests for reconsideration and for appeal.** Illinois regulations state that, during a post-payment audit, "the provider must cooperate and furnish to the Department, or to its authorized designee, pertinent information regarding claims for payment," and the state may deny or suspend payment to any provider who fails to grant the state timely access to full and complete records [Illinois Administrative Code 89-140.28 and -140.30]. New York regulations allow providers 30 days after receiving the draft findings, to object to the findings, and "any objection must include a statement detailing the specific items of the draft report to which the provider objects and provide any additional material or documentation which the provider wishes to be considered in support of the objections" [18 CRR-NY 517.5]. Ohio regulations state that when the provider requests Informal Reconsideration, they must provide "the basis for requesting reconsideration; and supporting documentation…." [Ohio Admin. Code 5160-57-04(B)(4)(b)], and after reconsideration, if the provider files an appeal with the court, they must "identify the decision being appealed and the specific grounds for the appeal" [Ohio Admin. Code 5160-57-04(B)(5)]. Similarly, Texas regulations specify that, after the provider exhausts the administrative process, they may appeal only if they send a written explanation of the appeal request and supporting documentation for the request [1 Tex. Admin. Code § 354.2217], and providers must submit an affidavit that all medical records were submitted.

- **Texas allows two to three months for the state to review supporting documentation prior to the appeal.** Texas regulations allow 60 to 90 days (depending on the type of claim involved in the finding) for the state to review the supporting documentation that the provider submits when contesting a finding [1 Tex. Admin. Code § 354.2217].

- **New York requires providers to implement plans to help ensure ongoing compliance with Medicaid requirements.** Specifically, New York regulations require Medicaid providers that are hospitals, residential health care facilities, home care

services agencies, providers of developmental disability services or mental disability services, and long-term care providers, to implement and maintain an "effective compliance program" to prevent, detect, and correct fraud, waste, abuse, and non-compliance with Medicaid requirements. As part of the compliance program, providers must complete an annual compliance plan that documents their strategy for identifying these risk areas and for addressing the risks through corrective action, and that includes training for provider staff to ensure compliance with Medicaid requirements; these provider plans are subject to review by the state department [18 NYCRR Part 521].

It is important that all parties involved in Colorado's Medicaid RAC program are active participants, and act in good faith, to ensure that public funds are used effectively and in line with Medicaid billing and reimbursement requirements. HCPF is responsible for being a good steward of taxpayer dollars. One way that HCPF can accomplish this is by ensuring that providers are billing accurately through reviews and training, and by recovering overpayments. When providers are not required to (1) participate in the administrative processes for RAC audits and for contesting findings prior to appeal, (2) explain and support the basis of their appeals, and (3) correct noncompliant practices that lead to RAC findings, it can negate the benefits of Colorado's RAC program efforts to reduce improper billing practices and billing errors, and to maximize the use of public funds for Medicaid services.

Policy Consideration for the General Assembly – The General Assembly may want to consider revising statute related to the Recovery Audit Contractor (RAC) program to require, or give the Department of Health Care Policy & Financing (HCPF) the authority to require Medicaid providers to:

- Participate in the preliminary administrative process to address audit findings, such as by requiring audit exit conferences and use of the Informal Reconsideration process, before filing an appeal with the Office of Administrative Courts.

- Provide the RAC and HCPF timely documentation to support an appeal within a time frame that would allow the RAC and HCPF to review and respond to the appeal prior to settlement and provide an explanation of the basis of their appeal beyond stating that the findings are arbitrary and capricious.

- Address the causes of any ongoing or repeat improper billing practices and billing errors identified through RAC audits. For example, this could include giving HCPF the authority to hold providers accountable by: (1) requiring providers to establish and implement corrective action plans, and (2) HCPF reviewing the corrective action taken by providers and taking other steps as appropriate to address improper billing.

Policy Consideration for HCPF – The Department of Health Care Policy & Financing (HCPF) may want to consider directing its Recovery Audit Contractor to increase the amount of time that providers have to request an exit conference after the providers have received a request for medical records for an audited claim. The ten-day time frame for providers to request an exit

conference was established by regulation at [10 CCR 2505-10, Section 8.076.2.H.A]. If the deadline were longer, more providers might request and participate in exit conferences. HCPF may also want to consider offering exit conferences for automated audits as well as complex.

Response

Department of Health Care Policy & Financing

Thank you for the suggestion. This particular timeline would need to be changed through an Medical Services Board rule change and posted for public comments. Per 10 CCR 2505-10 8.076.2.H. it states “8.076.2.H. A Provider subject to a review or audit may request an interview in person or by telephone with the Department or its designees before the final written post-review correspondence is released. The request for an interview must be in writing, specify whether an in-person or telephone interview is being requested, and must be received by the Department within ten (10) calendar days from the date of the Department’s request for records. During this interview, the Provider may discuss the preliminary findings of the review or audit, what documentation the Provider may use to refute the findings, and the next steps in the review or audit process.” This rule is not just for RAC audits but is for all audits from the Department. While HMS and the Department are in agreement that the timelines for notices, informal reconsiderations and appeals are very strict, they are all in statute, which makes the updates to specific timelines very difficult to change. We can commit to researching and following up with the federal government and the state legal counsel to verify steps needed to change the timelines for RAC audits.

Additionally, these rules align with Colorado laws, CMS rules, and federal laws regarding audit timelines, which would require further research and work with CMS to verify if we could create specific timelines for RAC through a SPA, or if we needed to change laws within the state or the federal rules. The RAC final rules do state that if there is a specific change for the program, including different timelines, appeals processes, or structure, there is potential that CMS can grant that authority through a SPA. We would be happy to explore those options.

Policy Consideration C – Case Review Timelines and Documentation of Review Staff Qualifications

HCPF's contract with HMS establishes deadlines for various RAC activities such as providers requesting Informal Reconsideration of findings or appealing findings; and HMS re-evaluating and issuing a determination in an Informal Reconsideration.

HCPF's contract with HMS also requires HMS to use "appropriately licensed, experienced health care professionals [during RAC audits] to pre-screen and make initial case review findings."

In our review of the sample of 100 claims that HMS had audited, we tracked the date of each of the activities outlined below and compared them to the contractual deadlines. We also reviewed other documentation in the audit files provided by HCPF for these claims, which included correspondence notifying providers about the audits, notes of any meetings with providers about the audit findings, and communications related to any time extensions requested by providers and granted by HCPF or HMS. The purpose of the work was to evaluate HMS' compliance with several of the deadlines listed below. For each one, we indicate the number of claims in our sample that were subject to the deadline:

1. Informal Reconsideration Requests. Providers that want an Informal Reconsideration of their findings must submit a request to HMS within 30 days after receiving a Notice of Adverse Action Overpayment Determination Letter (Notice). Notices inform providers of the findings from an audit and identify the amount of overpayments the provider is expected to repay. Our sample included 21 claims for which providers requested Informal Reconsiderations (13 automated and 8 complex).

2. Informal Reconsideration Determinations. If HMS believes it will be unable to render a decision on the request for Informal Reconsideration within 45 days after the provider's request, they must submit a written notification to HCPF and the provider stating why they are unable to render a timely decision. The letter must be sent to the provider no later than the forty-fifth day after the provider's request. [Contract Sections 1.18.5 and 1.18.6]

3. Appeals. Providers have 30 days to file an appeal after one of the following: (1) receiving a Notice, (2) receiving a determination in an Informal Reconsideration, or (3) receiving a letter that HMS is unable to render a timely decision in an Informal Reconsideration. Our sample included 16 claims for which providers appealed the findings (14 automated and 2 complex).

4. Appeal Summaries. HMS must provide HCPF a case summary within 30 days after HMS has been notified of an appeal.

In our review, we also looked for evidence that the claims had been reviewed by properly qualified HMS staff.

Case Review Results

Timelines

From our sample review, we found instances where HMS and providers appeared to miss contractual deadlines, as described below. HCPF did not provide supporting evidence in response to the discrepancies identified.

Informal Reconsideration Requests. For 5 of the 21 claims we reviewed for which providers requested Informal Reconsiderations, the request was made past the 30-day deadline from when the provider received a Notice. The Informal Reconsiderations were requested between 39 and 160 days from the date of the Notice. For four of the claims, we were unable to ascertain if the deadline was met due to incomplete information in the case files. For the remaining 12 cases, we verified that the Informal Reconsideration was filed on time.

Informal Reconsideration Determinations. For the 21 claims we reviewed for which providers requested Informal Reconsiderations, we found:

- HMS was unable to render a timely decision on five claims but did not notify providers within the 45-day deadline. The notifications were issued between 49 and 231 days after the Informal Reconsideration was filed.
- We were unable to verify when HMS made its determination on six of the Informal Reconsiderations due to incomplete information in the case files.
- We verified that the Informal Reconsideration Determinations were made on time for the remaining 10 claims.

Appeals. For 4 of the 16 claims in our sample for which providers submitted appeals, the appeals were filed after the 30-day deadline. All four were from automated audits. The appeals were filed between 35 and 159 days after the providers received Notices, determinations in Informal Reconsiderations, or a notice that HMS was unable to render a timely determination in an Informal Reconsideration. The Office of Administrative Courts makes the determination of whether to accept an appeal that is filed after the 30-day deadline.

Appeal Summaries. For 3 of the 16 claims in our sample for which providers filed appeals, we could not identify Appeal Summaries in the case files. For one claim, the appeal case was still open, so an Appeal Summary had not been submitted. For the other 12 claims, we verified that Appeal Summaries were submitted on time.

In some cases, HCPF may approve extensions to the deadlines, such as allowing providers additional time to submit Informal Reconsideration requests on a case-by-case basis, or allowing HMS more time to issue a determination in an Informal Reconsideration. The Office of Administrative Courts may also accept late appeals for some cases. As such, these missed deadlines are not necessarily violations of the RAC contract. However, consistent adherence to the deadlines is important to help ensure that provider audits are processed efficiently and equitably and to promote equitable treatment for providers.

Staff Qualifications

Colorado RAC audit review documentation does not identify which HMS staff performed medical review activities. All clinical reviews are indicated as reviewed by "Clinical Staff at HMS." Because the reviewer was not identified, we were not able to verify that the reviewer had the required qualifications to perform the review.

Specifically, we found the following:

- Claims undergoing complex audits. For all 24 claims, the review files indicated that the claims had been reviewed by "Clinical Staff at HMS"; however, there was no documentation that the medical record reviews were conducted by qualified staff to identify or verify findings. Out of these 24 claims, HMS identified 15 overpayments, and providers requested Informal Reconsiderations for and/or appealed 3 of the 15. Based on the documentation HCPF provided, we could not verify that any of these three claims were reviewed by a physician, as required.
- Claims undergoing automated audits. For 13 of the 76 claims in our sample that underwent automated audits, providers requested Informal Reconsiderations and/or appealed the findings. Based on the information HCPF provided, we were not able to identify documentation showing whether these claims were reviewed by a physician, as required. The remaining 63 claims in our sample were not appealed and the provider did not request an Informal Reconsideration, so they were not required to be reviewed by a physician.

HCPF's contract with HMS does not require that HMS document the information of an individual who conducts a claim review. According to HCPF, HMS does maintain this information and HCPF reviews it as needed on an ad hoc basis or in the case of appeals. Including the reviewer's information in a case file is considered a best practice as it allows the oversight agency to monitor the RAC's compliance with contract requirements related to staff qualifications. To monitor HMS' use of qualified medical professionals for claims reviews, HCPF would need to establish a requirement in the RAC contract for HMS to document the names and, when appropriate, the qualifications of staff who review each claim. HCPF would then be able to periodically review claims to verify HMS' compliance with RAC contract requirements related to qualified staff reviews.

Policy Consideration for HCPF – The Department of Health Care Policy & Financing may want to consider:

a) Establishing a mechanism for tracking the frequency of and reason for missed deadlines in the case review process to help identify and address any systemic problems in the process and to maximize efficiency and fairness.

b) Requiring its Recovery Audit Contractor to document the names and qualifications of staff that review each claim during an audit, an Informal Reconsideration, or an appeal.

Response

Department of Health Care Policy & Financing

The Department does require reporting on missed deadlines from HMS, as well as reporting on provider compliance, which we have used to make additional communications to the specific providers who are having issues with turning in medical records or documentation during the course of an audit. While we have these reporting mechanisms in place, we can always commit to having more robust or clearer reporting so that there is transparency in the processes. We also would like to ensure that any reporting is also communicated externally, as this may help with transparency and confidence in the program.

HMS does track the exact reviewer for each claim they make a determination on; however, historically we have not put this into our reporting since the vendor maintains a URAC certification, which is the national standard where the accredited business has an annual review of the staff in order to ensure that the highest requirements for licensure are maintained and documented. We have already started to put in place more frequent verifications of licensure.

The Department can commit to reviewing reporting, standards, and requirements with CMS and with other states so that we can define what the best practice is and what the standard should be so we are in alignment with other RAC programs and in alignment with CMS. Any changes to the reporting, standards, and best practices will be updated as needed in the following documents; an approved CMS SPA for the RAC program, contract amendments or contract transmittals, as well as policies and procedures.

Chapter 3: RAC Program Balance of Fiscal Accountability with Access to Care

Colorado House Bill 23-1295, which is codified as Section 25.5-4-301(3.7), C.R.S., directed that this evaluation review a number of aspects of the Recovery Audit Contractor (RAC) program to assess how providers are affected by the program in terms of:

- **The payment model and percentage used to compensate the RAC.** Statute required us to examine "the level of payments sufficient to maintain a RAC contractor"; the "impacts on providers related to a contingency fee significantly above the federal standard;" and "other states' … financing mechanisms" for RAC contractors and to identify practices used in other states to compensate the RAC to identify underpayments to providers. [Sections 25.5-4-301(3.7)(a)(I), (a)(III)(D), (a)(VI), (b)(I), (b)(II)(A), and (b)(II)(E), C.R.S.]

- **The lookback period for RAC audits.** Statute required us to assess the impacts on providers and Medicaid beneficiaries of the RAC program's seven-year lookback period, which exceeds federal standards for Medicaid RAC programs; the implications for providers and the State's General Fund of adjusting the lookback period; and the lookback periods used in other states. [Sections 25.5-4-301(3.7)(b)(II)(A), (a)(IV), and (a)(III)(B), C.R.S.]

- **The administrative burden on providers.** Statute directed us to assess the administrative burden on providers associated with undergoing RAC audits and "the impact of audits on provider participation and access to care." [Sections 25.5-4-301(3.7)(a)(V) and (a)(VII), C.R.S.]

- **How the RAC program supports providers.** Statute required us to evaluate how the RAC program supports providers throughout the audit process and how it is used to improve provider billing. This included specific requirements to evaluate (1) how the Department of Health Care Policy & Financing (HCPF) addresses provider concerns with the RAC program and (2) if federal regulations allow flexibility in establishing timelines and processes for when overpayments are identified, when repayments are due from providers, and when HCPF must refund the federal government its share of recoveries. [Section 25.5-4-301(3.7)(a)(II), (a)(III)(C), (a)(V), (a)(VII), (b)(I), (b)(II)(E), C.R.S]

- **Cost-Benefit Analysis.** Statute required us to "consider … how the state should evaluate the cost-benefit analysis to determine whether the … [RAC] program is striking the right balance between accountability and access to care." [Section 25.5-4-301(b)(II)(D), C.R.S.]

- **Improvements to the RAC program.** Statute required us to seek ways that HCPF could improve "provider education, training, and error rates" and "the timing [for] …

assessing when a potential overpayment is “identified.”” [Sections 25.5-4-301(3.7)(b)(II)(E) and (b)(II)(C), C.R.S.]

This chapter discusses our review and conclusions in these areas.

Finding 6 – Claims Limits on RAC Audits

One way the burden on providers can be minimized is by limiting the number of claims included in RAC audits in a given time frame. HCPF has established limits in terms of (1) the number of claims per provider that can be audited in a given time period and (2) the frequency of audits of any one provider.

Most states have different limits, such as limiting RAC audits to a percentage of total claims submitted by a provider in a year, or numerical records limits that differ from Colorado's. States will set these limits based on their own RAC program objectives and focus areas.

What Work Was Performed, What Was the Purpose, and How Were the Results Measured?

We reviewed the claims limits that HCPF has established for RAC audits, interviewed HCPF staff, interviewed providers, and reviewed documents submitted to us by providers to evaluate the use of RAC audit claims limit.

The purpose of this work was to assess whether HMS has applied the established limits as HCPF intended, and to assess concerns regarding the limits raised by providers.

Federal regulations at 42 CFR § 455.506(e) require states to "set limits on the number and frequency of medical records to be reviewed by the RACs, subject to requests for exception from RACs to States."

The RAC contract requires HMS to apply limits on its audits in accordance with direction from HCPF. Specifically, the contract states "Contractor shall calculate limits on the amount of claims and/or medical records that can be audited for each review conducted by Contractor. The Department will approve formulas and methodology to be used by Contractor to calculate the limits. The Department will also determine and approve maximum limits on the amount of claims and/or medical records that can be audited. Contractor shall adhere to the limits for the amounts of claims and medical records that can be audited for each review as directed by the Department." [1.13.2.6.]

HCPF used transmittals to establish and communicate specific limits for RAC audits during both the 2018 and 2021 RAC contracts. The audit limits are expressed in terms of the number of claims or number of medical records. As of March 2023 (the most recent update), the limits are as follows:

> **Frequency** – For both complex and automated audits, HCPF requires that HMS allow for a 45-day break between the initiation of new RAC audits, which means that a provider can only be sent a new Medical Record Request Letter or Notice every 90 days. HCPF also prohibits HMS from including a provider in an automated audit and a complex audit at the same time.
>
> **Number of Claims** – For complex audits, HCPF has established upper limits on the number of medical records HMS may request each month for audits of inpatient claims, with different limits depending on the type of provider and type of claim being audited. For

example, for a large hospital undergoing a complex audit, HMS may request up to 600 medical records per month; for a small hospital, the limit is 20 records per month. For complex audits of hospice claims, HCPF has established a limit of 10 cases per month.

For automated audits, HCPF allows HMS to include up to 800 claims per provider per audit. However, HMS may exceed this claims limit if approved to do so by HCPF. Because automated audits identify overpayments based on information in the claims database, providers are not required to provide any medical records.

Contract transmittals sent by HCPF to HMS included the following limits for complex audits:

Exhibit 10: Tiers and Limits 2023, Effective March 14, 2023

Tier Name	Hospital Reimbursement (FY 2021- 2022)	Monthly Maximum Claims Limit
Alpha	$250 Million+	600
Beta	$69 Million - $250 Million	400
Gamma	$39 Million - $69 Million	200
Delta	$19 Million - $39 Million	100
Epsilon	$9 Million - $19 Million	50
Zeta	$1 Million - $9 Million	25
Kappa	< $1 Million	20
Sigma	Out of State Facilities	10
Source: HCPF Contract Transmittal dated March 14, 2023		

Physician-Administered Drug (PAD) Complex Audit Claims Limits

In 2016, the RAC claims limits methodology for PAD claims was based on previous Fiscal Year reimbursements to that provider location, as identified by the Provider Medicaid ID.

As of March 14, 2023, the PAD claims limits will be a maximum of 50 claims per month, with the limit based on the provider location, as identified by the Provider Medicaid ID.

Hospice Complex Audit Claims Limits

In 2016, the RAC claims limits methodology for hospice claims was based on the previous Fiscal Year reimbursements to that provider location as identified by the Provider Medicaid ID. These claims limits were built for inpatient audits only.

As of March 14, 2023, the RAC claims limits will be a maximum of 10 patient cases per month, with the limit based on the provider location, as identified by the Provider Medicaid ID.

What Problem Did the Work Identify?

We identified challenges related to the application of the RAC audit claims limits that may be exacerbating provider administrative burden. HCPF informed us in multiple interviews that HMS has been instructed to apply the claims limits based on the “Provider Location ID”, which is unique to a provider’s physical location. A large health care system with multiple locations should have a unique Provider Location ID for each physical location, despite being part of the same overall health system or ownership entity.

Through interviews with providers, and our review of documentation submitted by providers, we identified that a misunderstanding exists between the provider community and HMS/HCPF regarding how the claims limits are applied to providers for the RAC audits. Our meetings with providers indicated that certain health care systems with multiple locations, that receive Medical Record Requests or an Automated Audit Notices of Adverse Action (Notices), can become overwhelmed due to the number of claims being audited. Based on our analysis, Notices sent from automated audits include an average of about 85 claims with findings. HCPF’s claims limits cap the number of claims per Notice at 800 but, in some cases, HCPF approves Notices with more claims. We spoke with one provider that showed that it received Notices related to an automated audit with more than 20,000 claims. The provider indicated that HCPF had authorized HMS to exceed the limits. Receiving a Notice for more than 800 claims in one automated audit cycle is not typical. In addition, although providers that receive Notices due to an automated audit are not required to provide any documentation, the providers interviewed as part of this evaluation stated they tend to review claims that are included in a Notice to assess their response, such as to file an Informal Reconsideration or appeal.

The contract transmittals sent by HCPF to HMS that established the claims limits do not clearly articulate that the claims limits are being applied based on the "Provider Location ID”, instead of the health care system. While there may be an understood application of the claims limits between HCPF and HMS, they are not clearly articulated in the contract transmittals nor communicated to providers.

As shown in **Exhibit 10**, for complex inpatient audits, the limits on the number of claims per provider that can be audited vary based on the amount the provider billed to Colorado Medicaid in the previous Fiscal Year. As an example, if Hospital A, Location 1 billed $150 million to Colorado Medicaid in Fiscal Year 2022, it is in the “Beta” tier for audits that occurred in Fiscal Year 2023. The “Beta” tier has a limit of 400 medical records per provider per month, which means that Hospital A, Location 1 can only be asked to produce 400 medical records per audit. However, if this health system has multiple locations, such as a main hospital with smaller satellite locations, HMS may also be auditing claims that occurred at Hospital A, Location 2. If Location 2 was in the “Epsilon” tier, the limit would be 50 records per month for a complex audit. Based on our review, it appears that HMS applies the record limits for Hospital A to each location individually. Thus, if HMS audits Location 1 and Location 2, it may request 400 medical records per audit cycle from location 1, and 50 from location 2.

As part of evaluating the administrative burden of the claims limits, we reviewed documents providers sent us. Our review of these documents found that confusion exists around the application of the complex inpatient claims limits. In response to a provider’s letter that included

concerns regarding the claims limits, HCPF acknowledged the necessity of creating clearer guidance.

Why Did the Problem Occur?

The guidance that HCPF has provided to HMS and providers on the application of the claims limits for RAC audits is vague. Specifically, it fails to provide a clear definition of "provider" in the application of claims limits for providers with multiple locations. For example, the term "provider" may be used to refer to a hospital system that handles the billing for all its individual locations as well as to refer to each individual location of the hospital.

Why Does This Problem Matter?

The application of the claims-based audit limits is designed to regulate provider burden, however the lack of clarity for providers has caused ongoing dissatisfaction. For example, the provider mentioned above that had received Notices for overpayments in more than 20,000 claims in a single automated audit described the administrative burden of responding to the audit of this many claims at one time as extremely challenging.

Further, two providers we interviewed explained that the administrative burden can be excessive due to the number of concurrent audits that occur at multiple locations. The application of the claims limits described above may also cause this additional burden on multi-location practices because Medical Record Request letters and Notices are sent to the practice's centralized location and overwhelms the staff who are responsible for managing RAC audits and other audits.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

Agree

Implementation Date: 06/2024

The Department agrees with this recommendation.

HCPF has published the structure for claims limits and the identification of what a provider's service location is. We agree and have already started to create documentation that better clarifies this information, which is based on CMS guidance and methodology. Further, we will post all the limits on the RAC website so that each provider and location understand the

claims limits in place, how they work, and the volume for that location. HCPF will also increase provider training on this issue.

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.

Finding 7 – Provider Support, Outreach, and Education

HCPF and HMS, as part of their RAC program duties, and in accordance with federal regulations, [42 CFR § 455.508], are charged with supporting providers during the RAC process through means such as provider outreach, education, and customer service. Both HCPF and HMS provide training and resources to providers on the RAC audit process. For example, HMS has presentations available on its website that give an overview of the RAC audit process and of the differences between complex and automated reviews. The website also has links to authoritative guidance, such as provider billing manuals. HCPF has similar resource links on its RAC webpage along with links to register for trainings that are offered roughly every month on specific aspects of the program. HMS is the primary point of contact for providers with respect to RAC audits and plays a key role in provider outreach and education. However, providers also communicate with HCPF directly by phone, email, or an online form that was implemented in March 2023 on the HCPF RAC website when questions or concerns about the program arise.

What Work Was Performed, and What Was the Purpose?

We performed the following procedures to gain information regarding the policies and practices HCPF and HMS have established to support and communicate with providers regarding the RAC program:

- Interviewed HCPF and HMS staff in charge of RAC audits.
- Reviewed HCPF policies and procedures, and the 2021 RAC contract with HMS.
- Obtained input from providers through several means. We conducted a survey of 4,162 providers and received 115 responses. A full description of the survey methodology can be found in Appendix A. We also interviewed four provider associations and talked with 11 providers through interviews and email exchanges.
- Performed online research for eight other states with RAC programs and interviewed representatives from five of those states.
- Reviewed tools and resources HCPF and HMS have for outreach and education regarding the RAC program, including webinars available on HCPF's website that provide an introduction to and overview of RAC audits; periodic outreach flyers and bulletins that provide updates and information regarding RAC audits; training available on HMS' website; and materials from an HMS Stakeholder Meeting in 2023.
- Reviewed monthly status reports submitted to HCPF by HMS. We requested all monthly reports from January 2020 through September 2023; HCPF provided nine reports from 2020, six from 2021, four from 2022, and one from 2023.
- Reviewed 10 weekly Quality Control Review reports submitted to HCPF by HMS. We reviewed reports from 2020, 2021, and 2023, as provided by HCPF.

The purpose of the work was to evaluate how HCPF addresses provider concerns; understand HMS' responsibilities for provider outreach and education; and identify potential best practices

from other states related to provider education, training, and support. Statute required that our evaluation consider these issues. [Sections 25.5-4-301(b)(III)(C) and (b)(IIE), C.R.S.]

How were the Results of the Work Measured?

HCPF maintains overall responsibility for the operation of the program, including monitoring provider concerns and education, as required by the State Plan Amendment.

According to the RAC contract, HMS has primary responsibility for conducting outreach to providers and managing questions or problems from providers related to the RAC program. Specific HMS responsibilities assigned in the RAC contract, include requirements for HMS to:

- Maintain a provider call center and respond to provider questions and requests for information "expeditiously, within forty-eight (48) business hours, maximum."
- Conduct periodic informal conferences with providers. This expectation is reiterated in a communication plan HMS developed, stating that HMS would "conduct regular telephone calls with providers, provider associations, and other interested parties to discuss the RAC program, our process, and our findings."
- Prepare and implement provider education plans. The contract requires HMS to develop a Provider Education Plan and provide it to HCPF within 10 business days after completing an audit, and conduct provider education at least once a quarter. It also requires provider education plans to "contain, at a minimum, … identification of common billing trends or issues that result in erroneous payments [and] the methods Contractor will utilize to communicate the trends and issues and corrective actions to Providers."
- Prepare and implement a provider outreach plan that outlines how HMS will inform providers about various aspects of a RAC audit, including audit policies, providers' rights to request extensions and exit interviews, and the appeals process.

What Problem Did the Work Identify?

HCPF and HMS have processes in place for informing providers about the RAC process and requirements. However, we identified shortcomings in these processes where we were not able to determine if HMS is complying with contract requirements, as described below.

First, we found that although HMS has a toll-free call center for providers, HCPF did not have data we could use to validate that provider communication from HMS met the 48-hour response requirement included in the RAC contract. HCPF stated that they monitor the 48-hour requirement on a weekly basis, but they do not maintain a historical log of all calls and response timing. Our review of the weekly reports HMS submitted to HCPF indicated that HMS tracks the number of calls and emails received from providers and whether a response was provided within 24-hours. However, we found no reporting by HMS about whether it was meeting the 48-hour response time requirement. Out of 10 weekly reports reviewed, HMS reported that zero calls out of the 359 calls received during that time were returned within 24-hours for seven of the 10 weeks and four calls were returned within 24-hours for the other three weeks. The

weekly reports did not provide enough information to determine whether all the calls required a response.

Second, although HMS has a formal exit conference process where it discusses audit findings with providers, we could not verify that HMS conducts periodic informal conferences or phone calls with providers or provider associations to discuss the RAC program, processes, and findings, as required by the customer service standards in the contract. The HMS presentations and webinars we reviewed did not indicate that HMS regularly held telephone calls or informal conferences with providers to help them understand the program. According to HCPF, providers can use the call center as needed to attain information related to the RAC program.

Third, HCPF provided us a single draft education plan that HMS prepared back in 2016 that does not fulfill the requirements of the current RAC contract. The plan is a broad outline of educational efforts that HMS prepared at the beginning of its tenure as HCPF's RAC. However, HMS does not appear to prepare formal provider education plans after it completes each audit to inform HCPF of any common billing errors HMS found through its audits or describe the content and materials HMS will use to educate providers to prevent such errors in the future. These specifics are required by the contract and appear to be intended to ensure that HCPF is aware of the kinds of errors and issues HMS finds in its audits and has approved the training HMS will give to providers to help correct these errors in the future. HCPF stated that they provide education to providers through provider bulletins, however this does not meet the contract requirement to develop provider education plans. We were not provided support to show that HMS conducted provider education quarterly.

We did not identify any deficiencies in the content of the outreach plan prepared by HMS, but noted that it has not been substantively updated since it was initially written in 2016. HCPF reported that it reviews the plan each year and HMS only updates it when HCPF determines it is needed.

Fourth, HCPF could not provide documentation to show how often providers have contacted HCPF directly or what types of concerns they raised with the RAC program. HCPF stated that it rarely receives concerns from providers directly and that most providers initially contact HMS with questions or problems.

Why did the Problem Occur?

HCPF is not enforcing some of the contract requirements for the RAC program, including for HMS to report on its outreach and education activities, including how well it is meeting the 48-hour response requirement, conduct periodic informal conferences with providers, and prepare and submit provider education plans after each audit. Our review of 20 monthly HMS status reports found no mention of such activities, although the contract requires that the monthly reports have a section describing the provider education and outreach activities from the previous month and upcoming activities.

Without such monthly reporting, HCPF lacks assurance that HMS is complying with customer service, communication, outreach, and education expectations. Further, the lack of reporting means there is no reasonably accessible, aggregated, documented information available to

gauge HMS' compliance with the RAC contract and evaluate whether there are gaps or deficiencies in these processes that contribute to the provider dissatisfaction discussed below.

HCPF also lacks written policies, procedures, and guidance for communicating with providers and addressing their concerns about the RAC program. Specifically, HCPF's policies and procedures do not (1) establish guidance or clear expectations for HCPF's own staff in responding to questions or concerns from providers, including time frames for responses, or (2) establish a mechanism for tracking communications from providers and the issues raised or how they were resolved. Our interviews with other states' RAC programs about their education and outreach efforts, found that they appear to be similar to Colorado in their means of informing providers about the program and offering provider education and none of them were able to provide written department policies for communicating with providers either. However, implementing policies and procedures or other guidance related to communicating with providers could help to manage provider relations and reduce provider frustration with the RAC program.

Why Does This Problem Matter?

A provider's experience with the RAC program is affected by the education and communication they receive from HMS and HCPF, and these elements influence provider satisfaction with the program. Responses to our provider survey indicated that some providers are dissatisfied with the RAC program in these areas. Four of the 28 questions in our survey related to education, communication, and support. For all four, provider responses indicated a high degree of dissatisfaction, as follows:

- Training and education – 45% (51 of 114) of respondents disagreed or strongly disagreed that the RAC program provides adequate training, education, and informational resources about audits. (Q 8)
- Clarity about how audit areas are selected – 41% (47 of 115) of respondents disagreed or strongly disagreed that audit selection criteria and methodologies were clearly explained to them. (Q 9)
- Collaboration – 46% (51 of 96) of respondents disagreed or strongly disagreed that the RAC program fosters collaboration and communication between providers and auditors. (Q 21)
- Balancing accountability and support – 58% (56 of 96) of respondents disagreed or strongly disagreed that the RAC program adequately balances its roles of detecting improper payments and supporting providers in compliance efforts. (Q 22)

The complete results of our survey are included in Appendix A.

Our review of the reasons providers left Medicaid, described in detail in Policy Consideration D of this chapter, found no instances of providers reporting they left because of issues with the RAC program. However, some providers and provider organizations we talked to during the evaluation stated that poor communication and education has caused some practices to consider whether they will continue to provide care to Medicaid patients.

Further, if providers experience a lack of response or delayed communications from HMS or HCPF, it can potentially make the RAC program less efficient and effective and increase the provider burden. For example, if providers cannot get timely, complete, and accurate answers to their questions or resolution of problems, they may undertake work to provide records that do not meet the RAC's needs, thus increasing their workload and cost. This could lead to HMS identifying an overpayment based on incomplete records and ultimately result in the provider, HMS, and HCPF dealing with Informal Reconsideration requests and appeals. These add not only to provider costs but also to the workload of HMS and HCPF. If providers do not receive regular education about common billing errors, they are likely to repeat them in future billings, leading to additional overpayments and all parties potentially incurring costs if those erroneous claims are later audited.

Finally, by not tracking communications from providers, HCPF is missing an opportunity to identify and analyze common themes or recurring issues. Such analysis could be used to improve the RAC program, including provider outreach, education, and support, and help HCPF hold HMS accountable for fulfilling its responsibilities in these areas. Providers that employ experienced medical billing professionals may have feedback that would be valuable in helping HCPF clarify policies and processes, better inform providers, and better educate them to use proper billing.

Recommendation No. 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.

Response

Department of Health Care Policy & Financing

A. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. We consider our network providers our customers and will more effectively track this response time and hold HMS more accountable going forward to better provider service, thereby enhancing the processes we have in place now.

B. **Agree**

Implementation Date: 08/2024

The Department agrees with this recommendation. Both the Department and HMS have policies and procedures in place for logging communications; however, HCPF can commit to creating better tracking and reporting to ensure that these types of engagements are tracked and documented in a manner that better creates transparency and can be used in reporting. Additionally, the Department can create educational materials with our vendor to ensure there is a process in place and expectations when a provider or association does reach out for an informal conference. This will align the contract with expectations and timelines that we can give to providers which will help ensure that we have the resources needed to schedule, follow-up and document the meetings and any outcomes we may have from these meetings.

Given that the challenge is largely about getting the providers to leverage the RAC system of Exit Conferences and Informal Reconsiderations - versus going straight to the appeals process - these enhancements will also serve to hold providers more accountable to following the process.

C. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. Accordingly, HCPF will create processes that better identify the common errors and issues found through each provider's RAC audit and will improve its communications that train providers to address such findings. The Department will also create policies that require providers to address repeat behaviors to better achieve the goals of the RAC program and to better hold providers accountable for addressing identified billing errors, thereby mitigating future overpayments within the Medicaid program.

The HMS provider portal also has reporting and trending in place to help providers review the statistics on what was reviewed, what the findings were, and the trends of the findings over the course of the audits. HCPF/HMS also provides monthly provider training.

D. **Agree**

Implementation Date: 12/2024

The Department agrees with this recommendation. While HMS does provide this reporting, HCPF can commit to updating transmittals and reporting to better define our requirements, reporting, and expectations for both the Department and our HMS vendor.

Addendum: During the evaluation, HCPF provided no documentation that HMS reports to HCPF on its outreach or education activities.

E. **Agree**

Implementation Date: 06/2025

The Department agrees with this recommendation. We will strive to accomplish this recommendation sooner than June 2024. The Department has policies and procedures for provider and external communications; however, HCPF can commit to making a specific tracking log, policies, procedures, and reporting that is specific to the RAC program and can create a robust reporting mechanism that will better help with tracking trends in the communications. We also can report on these externally which will help with transparency for our stakeholders. We have already begun developing a tracking system via a ticket system which would show open items we need to follow up on and can help to create standards for response times and ensure that we are communicating those expectations externally.

Policy Consideration D – Lookback Period Impact on Providers and HCPF

The lookback period refers to the time between when a claim was paid and when it was audited by the RAC. The lookback period can be calculated several ways, but in Colorado, it is the period between the date of claim payment and the date a provider first receives notification of an audit. For complex audits, the first notification is the *"Medical records request letter"*, which informs the provider of the claims being audited and requests the medical records for those claims. For automated audits, the first notification is the *"Notice of Adverse Action, Overpayment Determination letter"*, which includes the recovery demand. This is because automated audits use data analysis to identify overpayments based on data in the claims database. Providers are notified only after the review of the claims has been completed and overpayments have been identified. Automated audits do not involve a review of provider medical records, unless providers should choose to submit records in the Informal Reconsideration phase of an audit.

Colorado's approved SPA permits a seven-year lookback period for Medicaid RAC audits, which is an exception to the federally established maximum of three years, and the longest lookback period granted by CMS. Colorado's lookback period for RAC audits is aligned with Colorado Medical Board policy 40-7,1.c, regarding medical record retention, which states "The Board recommends retaining all patient records for a minimum of seven years after the last date of treatment, or seven years after the patient reaches age 18 - whichever occurs later." Additionally, hospitals are required under state regulations to maintain records for at least 10 years. [6 CCR 1011-1, 11.4(B)]

Exhibit 11 shows the lookback periods of other states that had operational RAC programs as of December 2023.

Exhibit 11: RAC Lookback Period Used in Other States

Lookback Period	States	
7 years	• Colorado	• Oregon
6 years	• New York	
5 years	• Georgia • Minnesota	• Texas • West Virginia
3 years	• Arizona • California • Connecticut • Hawaii • Illinois	• Indiana • Mississippi • Nevada • New Mexico • North Carolina • South Carolina
Source: BerryDunn research on state RAC programs.		

HCPF told us it has several reasons for its use of a seven-year lookback period.

First, after unsuccessfully soliciting for RAC services in 2014, HCPF received feedback that the lookback period of three years was too short for audits to be financially viable for contractors; longer lookback periods can provide a larger window of opportunity to identify overpayments. HCPF then applied and was approved for the SPA that allows the seven-year lookback period.

Second, HCPF stated that the seven-year lookback period for RAC audits can help identify systemic billing problems and correct them, such as through policy changes, before a federal audit. The Office of Inspector General, U.S. Department of Health and Human Services (HHS OIG), conducts audits and reviews of State Medicaid agencies and, according to HCPF, may look at claims as old as 10 years. The seven-year lookback period not only allows HCPF to resolve billing problems to reduce possible HHS OIG findings, but it also demonstrates the State's commitment to program integrity. In the event that HHS OIG identifies a deficiency that causes or allows overpayments, HCPF would utilize a post-payment review process other than the RAC audit to audit and potentially recover overpaid funds from providers.

Third, HCPF stated that the lookback period for HCPF's other post-payment reviews is seven years, and that using the same period for RAC audits provides consistency.

The statute requiring this evaluation raised two main questions about the seven-year lookback period - (1) what is the impact on providers, and (2) what would be the impact if the period was reduced. [Sections 25.5-4-301(3.7)(b)(II)(A), (a)(IV), and (a)(III)(B), C.R.S.]

To address these questions, we conducted the following analyses:

1. Determined the proportion of claims actually audited that were paid in each year within the lookback period for RAC audits performed from January 2021 through June 2023.
2. Analyzed how the lookback period relates to the number of requests for Informal Reconsideration and the number of appeals providers submit on claims audited.
3. Assessed provider perspectives on the burden caused by a long lookback period and whether it causes providers to leave the Medicaid program.
4. Estimated how a reduction in the lookback period might affect recoveries.

Our analysis of the lookback period is limited to the RAC program and is not applicable to other post-payment reviews HCPF performs.

Claims Audited by Lookback Period

We analyzed data from the RAC audits performed between January 2021 and June 2023 and calculated the lookback periods of the claims audited. We then grouped the claims by their effective lookback period. To calculate the lookback period, we subtracted the difference between the "Medical Record Request" letter date (complex reviews) **or** the "Notice of Finding" letter date (automated reviews) and the "Claim Paid Date".

The results of our analysis are shown in Exhibits 12 through 14. We found that most of the claims (93%) that underwent a RAC audit during this period were within a five-year lookback period and about 66% were within a three-year lookback window, which is the maximum

lookback period established by CMS. **Exhibit 12** shows the distribution of all audited claims across the seven-year lookback period.

Exhibit 12: Total Audits Performed for both Automated and Complex Reviews

From January 2021 through June 2023

Lookback Period (Years) [1]	Number of Claims Audited	Percent of Total Number of Claims	Dollar Value of Identified Overpayments	Percent of Total Audited Claim Value
0-1[2]	2,287	0.5%	$2,659,331	**0.9%**
1-2	77,680	16.1%	$138,983,578	**47.5%**
2-3	34,673	7.2%	$50,390,999	**17.2%**
3-4	60,186	12.5%	$46,369,889	**15.8%**
4-5	140,233	29.1%	$34,333,705	**11.7%**
5-6	78,083	16.2%	$10,214,278	3.5%
6-7	89,253	18.5%	$9,585,401	3.3%
7-8	114	0.0%	$62,062	0.0%
Grand Total	**482,509**	**100.0%**	**$292,599,243**	**100.0%**

Source: BerryDunn analysis of data from HCPF on claims audited by HMS.

1 – The Lookback Period refers to the time period when a claim was paid relative to when it was audited by the RAC. Lookback Period 1-2 includes claims that were audited more than one year, but less than two years, after being paid.

2 – The claims with a lookback period of less than one year were audited outside of the timely filing period, which in Colorado is one year from the claim's *Date of Service*. The lookback period is calculated differently by using *Letter Date – Claim Paid Date*. The *Claim Paid Date* will always be after the *Date of Service.*

Exhibits 13 and 14 provide an analysis of the frequency of the lookback period lengths. **Exhibit 13** shows that about 57% of the automated audits had an effective lookback period of less than five years. **Exhibit 14** shows that about 98% of complex audits have an effective lookback period of less than five years.

Exhibit 13: Frequency of Lookback Period for Automated Audits

From January 2021 through June 2023

Lookback Period (Years) [1]	Number of Claims Audited	Percent of Total Number of Claims Audited
0-1[2]	2,167	**0.6%**
1-2	20,920	**5.5%**
2-3	22,847	**6.0%**
3-4	46,133	**12.0%**
4-5	126,083	**32.9%**
5-6	77,047	20.1%
6-7	88,173	23.0%
7-8	114	0.0%
Grand Total	**383,484**	**100.0%**

Source: BerryDunn analysis of data from HCPF on claims audited by HMS.

1 – The Lookback Period refers to how long ago a claim had been paid at the time it was audited by the RAC. Lookback Period 1-2 includes claims that were audited more than one year, but less than two years, after being paid.

2 – The claims with a lookback period of less than one year were audited outside of the timely filing period, which in Colorado is one year from the claim's *Date of Service*. The lookback period is calculated differently by using *Letter Date – Claim Paid Date*. The *Claim Paid Date* will always be after the *Date of Service*.

Our analysis identified 114 claims audited that had a lookback period longer than seven but less than eight years, and were included the tables above. HCPF did not provide an explanation for these claims.

Exhibit 14: Frequency of Lookback Period for Complex Audits

From January 2021 through June 2023

Lookback Period (Years) [1]	Number of Claims Audited	Percent of Total Number of Claims Audited
0-1[2]	120	**0.1%**
1-2	56,760	**57.3%**
2-3	11,826	**11.9%**
3-4	14,053	**14.2%**
4-5	14,150	**14.3%**
5-6	1,036	1.0%
6-7	1,080	1.1%
Grand Total	**99,025**	**100.0%**

Source: BerryDunn analysis of data from HCPF on claims audited by HMS.

1 – The Lookback Period refers to how long ago a claim had been paid at the time it was audited by the RAC. Lookback Period 1-2 includes claims that were audited more than one year, but less than two years, after being paid.

2 – The claims with a lookback period of less than one year were audited outside of the timely filing period, which in Colorado is one year from the claim's *Date of Service.* The lookback period is calculated differently by using *Letter Date – Claim Paid Date.* The *Claim Paid Date* will always be after the *Date of Service.*

Relationship Between Informal Reconsideration/Appeal Request and Length of Lookback Period

We then analyzed the relationship between the length of the lookback period and the rate of Informal Reconsideration requests and appeals to assess whether a potential correlation exists. These analyses compared the total number of audited claims where an overpayment was found, by lookback period to the total number of those claims that resulted in an Informal Reconsideration request or an appeal.

Exhibit 15 compares the Informal Reconsideration request and appeal rates by lookback period to show whether there is a relationship between the length of the lookback period applicable to an audited claim and the rate of Informal Reconsideration request and appeal by providers. As shown, it appears that providers are less likely to request an Informal Reconsideration or appeal older audited claims than newer claims.

Exhibit 15: Complex and Automated Audited Claims with Overpayment Findings That Had Informal Reconsiderations and Appeals by Lookback Period

Lookback Period (Years) [1]	Total Number of Claims Audited With Overpayment Findings[3]	Total Number of Claims With Findings That Had Informal Reconsideration Requests	Percentage of Claims With Findings That Had Reconsideration Requests	Total Number of Claims with Findings Appealed[2]	Percentage of Claims with Findings Appealed[2]
0-1[2]	2,244	299	13.3%	231	10.3%
1-2	52,137	18,461	35.4%	8,929	17.1%
2-3	28,899	10,070	34.8%	7,253	25.1%
3-4	52,457	14,882	28.4%	7,191	13.7%
4-5	132,353	29,030	21.9%	10,712	8.1%
5-6	77,765	16,169	20.8%	5,317	6.8%
6-7	88,964	17,791	20.0%	7,434	8.4%
Grand Total	**434,819**	**106,702**	**24.5%**	**47,067**	**10.8%**

Source: BerryDunn analysis of data from HCPF on claims audited by HMS.
1 – The Lookback Period refers to how long ago a claim had been paid at the time it was audited by the RAC. Lookback Period 1-2 includes claims that were audited more than one year, but less than two years, after being paid.
2 – The claims with a lookback period of less than one year were audited outside of the timely filing period, which in Colorado is one year from the claim's "Date of Service."
3 – Only includes claims with findings for the purposes of assessing the Informal Reconsideration and Appeal Rate accurately

According to providers we interviewed, they retain medical records in compliance with Colorado regulations, which require that records be retained by hospitals for 10 years and by non-hospital providers for seven years. However, it may be more time consuming for providers to locate older records, which might help explain why the rate of Informal Reconsideration requests and appeals for lookback years six and seven are lower than for earlier periods.

Impact on Providers

As discussed in more detail in the Provider Burden section of this chapter, we reviewed the limited information available on the reasons providers gave for leaving the Medicaid program over the last five years and did not find any indication that the length of the lookback period prompted any provider departures. However, the length of the lookback period is a point of dissatisfaction for most providers that responded to our survey and who we interviewed. In our provider survey, which was sent to 4,162 providers, 67 of the 95 providers (71%) that responded to our question regarding the lookback period indicated that the seven-year lookback period poses a challenge due to the age of the records.

Open comments on the survey and information we gathered through interviews with 10 providers and three provider organizations indicate that the primary issues providers have with the seven-year lookback include:

1. Electronic health record system updates or changes cause older records to be archived or maintained in legacy systems, and some providers archive records for patients who are deemed inactive by their internal policies. Retrieving records from old systems or that are maintained in hard copy can require the expenditure of significant staff time.
2. Medical coding guidance changes regularly, and during a seven-year period, the guidance for billing a specific service can change multiple times. Providers stated that they typically analyze Notice of Adverse Action letters to assess whether they agree with the RAC audit findings. This helps the provider decide whether to request an Informal Reconsideration or appeal and whether they need to make changes to their coding and billing practices to come into conformance with billing requirements. Providers noted that assessing older claims to validate findings is more time consuming when they need to refer to previous versions of coding and billing guidance.
3. Reviewing old claims does not help providers understand current billing requirements or implement billing practice changes, since older claims were often submitted under different requirements. Some providers expressed frustration with learning that they may have been billing incorrectly for years but did not find out until a RAC audit was conducted as many as seven years later.

Policy Consideration - We do not provide a suggestion on the length of the lookback period for the Colorado RAC program, as this is a policy decision for the Department of Health Care Policy & Financing and the General Assembly. However, we do report the results of these analyses to provide decision-makers with detailed information on the lookback period and possible outcomes if the decision is made to make a change.

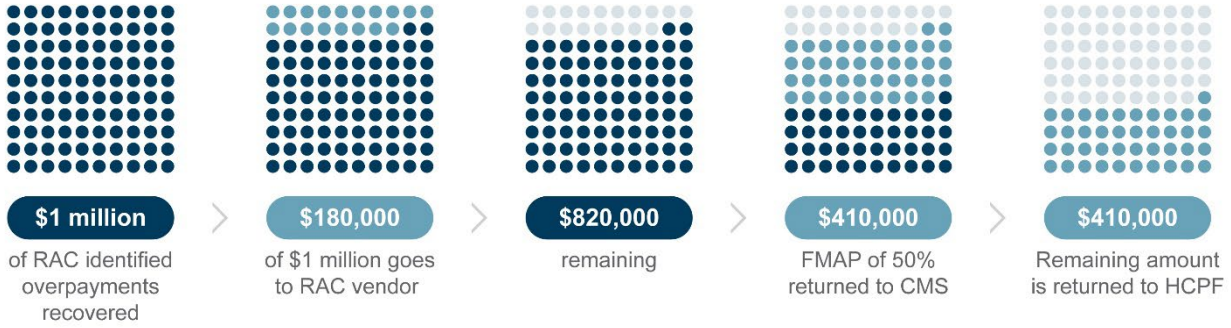
Policy Consideration E – Financial Implications of a Reduced Lookback Period

Medicaid is jointly financed by the federal and state governments. The federal share, known, as the Federal Financial Participation (FFP) rate, typically ranges from about 50 to 56% in Colorado, but can be as much as 90% for certain eligible individuals. When overpayments are identified during a RAC audit, the RAC contractor is to be paid from recovered amounts and the state must refund to the federal government its share of overpayments.

The exhibit below shows a standard Medicaid RAC contract payment flow. In this exhibit, the following assumptions were used:

1. Contingency fee rate of 18% for which FFP will be available
2. Federal Medical Assistance Percentage (FMAP) rate of 50%, which means a state share of 43.8%

Exhibit 16: Example of RAC Overpayments Recoveries Financial Flow



Source: Government Accountability Office. 2023. *CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program*. (GAO Publication No. 23-106025). Washington, D.C.: U.S. Government Printing Office. Accessed January 23, 2024 https://www.gao.gov/assets/gao-23-106025.pdf

To assess the potential financial impact of reducing the RAC lookback period, we started by reviewing the fiscal note for the introduced version of House Bill 23-1295. The introduced version of the bill, which is not the version that was ultimately passed, would have established a statutory maximum lookback period of three years that would apply to all audits conducted by HCPF, not just RAC audits. As such, the fiscal note contained an estimate that the provisions of the introduced bill, in combination, would result in a 50% reduction in audit recoveries. This estimate is not all related to the RAC program. HCPF also provided their analysis of the financial implications to the RAC program that could result from reducing the lookback period to three years. We subsequently performed our own analysis of data provided by HCPF to assess the financial implications of a reduction in the lookback period. The results of that analysis are shown further in this Policy Consideration.

We analyzed HCPF data on the number of claims that were audited in 2021, 2022, and 2023, and the amount of overpayments identified from the audits. We grouped the data into time frames of (1) claims that were three years old or less at the time of audit, or (2) claims that were more than three years old at the time of audit. The results are shown in the exhibits below.

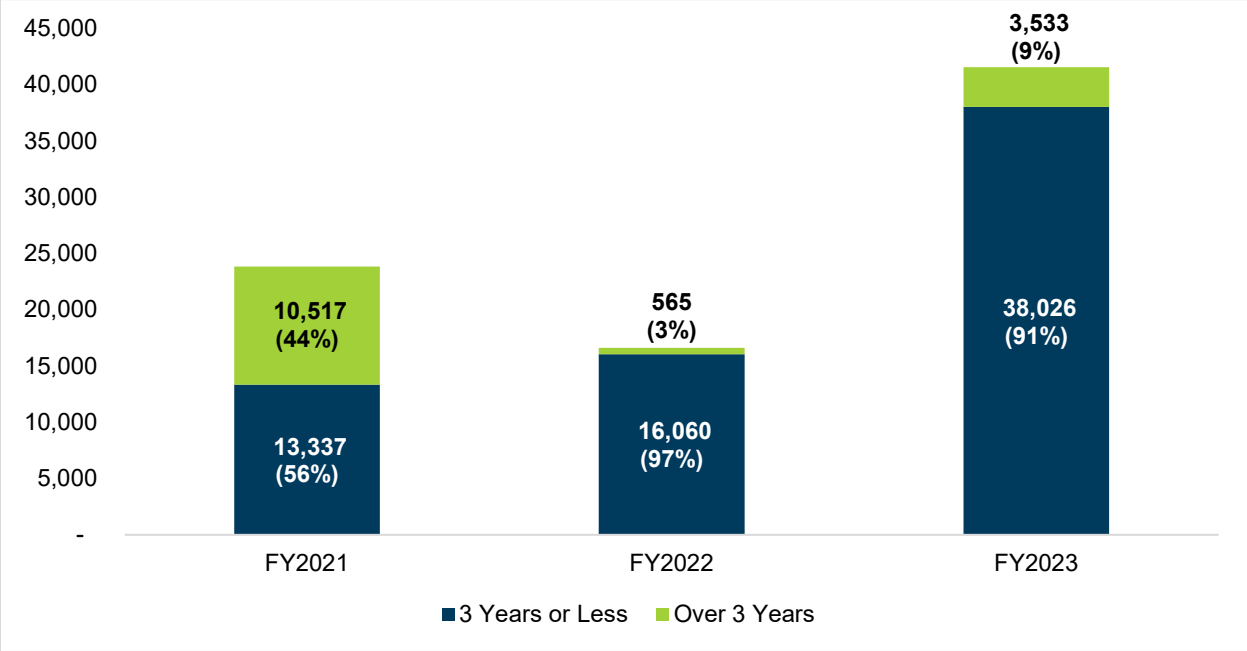
Limitations: Our analysis used the amount of overpayments that were identified in RAC audits, not the amount actually recovered. Recovered amounts may be lower than identified amounts in some cases due to provider appeals in which HCPF may settle with providers to accept a repayment that is less than the total identified overpayment amount. Further, our analysis was not intended to produce a specific estimate of reduced recoveries from a shorter lookback period; it was designed to provide insight into the potential financial magnitude of changing the lookback period from seven to three years. The analysis is also limited by the historical nature of the data used and the possibility that future audit scenarios and RAC program focuses could result in different recovery rates and dollar values.

As shown below, our analysis indicates that a three-year lookback period is likely to reduce recoveries from RAC audits by an average of $26 million per year, or 30% and reduce the number of claims audited by an average of about 120,000 per year, or 58%. These figures are a simple average across the three years in our analysis and they assume no other changes to the RAC program, such as changing the audit scenarios.

More specifically, in 2023, for complex audits, over 90% of claims audited and nearly 90% of the identified overpayments were from a lookback period of three years or less while, for automated audits, only about 2% of claims reviewed and 12% of identified overpayments were from a lookback period of three years or less. These results indicate that implementing a three-year lookback period would likely reduce the proportion of claims audited and the amount of overpayments found through complex reviews by only about 10%, but would likely reduce the proportion of claims audited and the amount of overpayments found through automated reviews by more than 90% and 75%, respectively. The exhibits below also show there is more year-to-year variance for automated audits than complex audits.

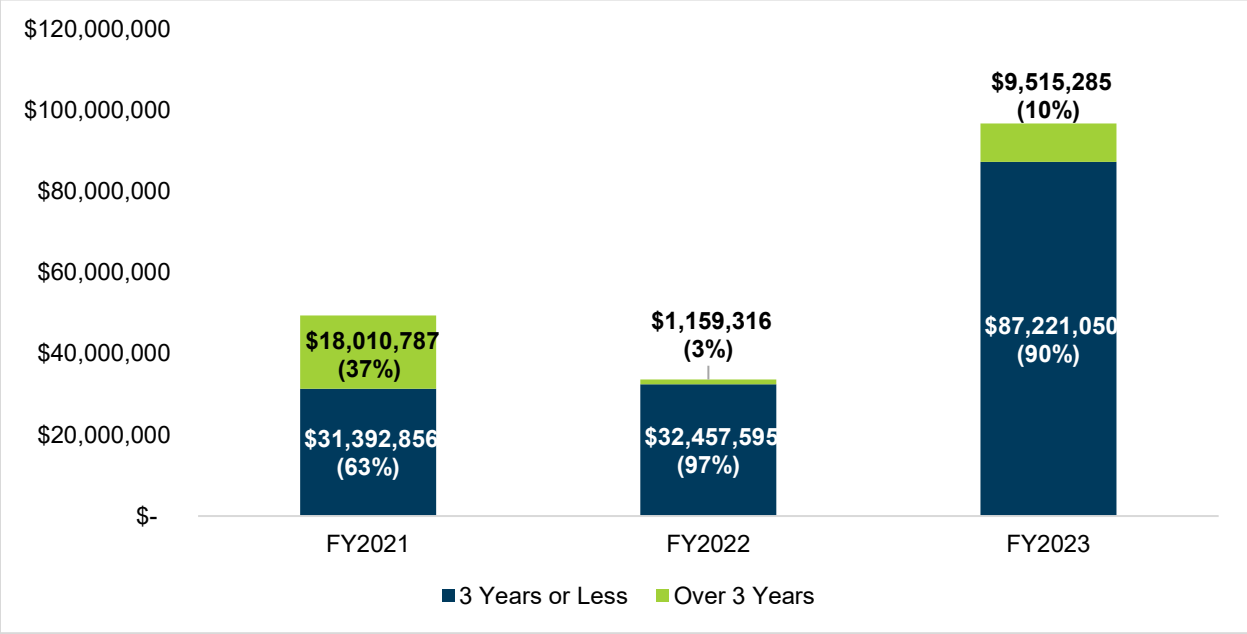
Exhibits 17 and **18** show our analysis for complex audits in Fiscal Years 2021 through 2023.

Exhibit 17: Number of Claims Audited - Complex Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023.

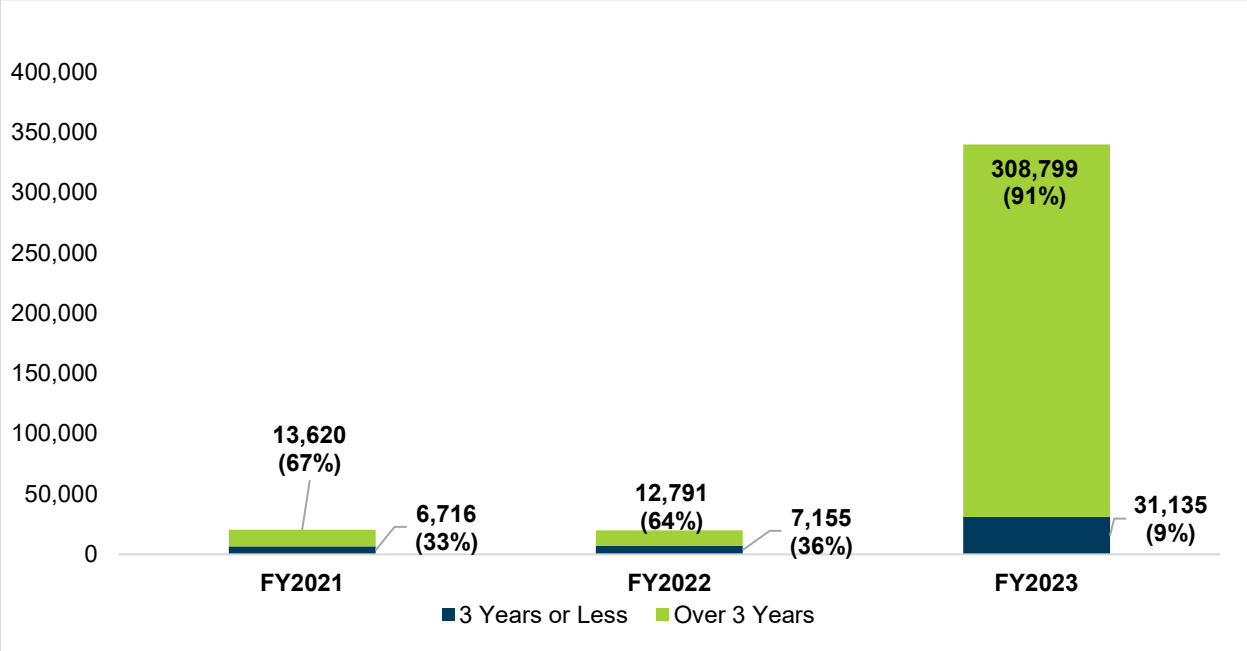
Exhibit 18: Dollar Value of Identified Overpayments - Complex Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023

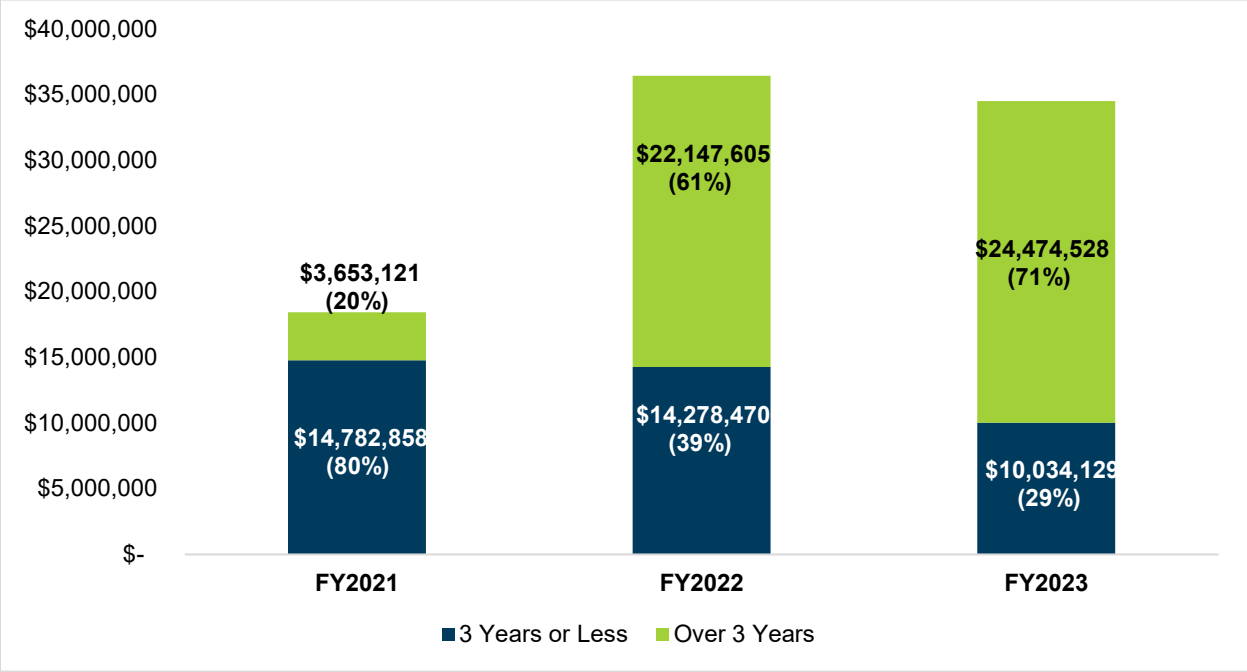
Exhibits 19 and **20** show our analysis for automated audits in Fiscal Years 2021 through 2023.

Exhibit 19: Number of Claims Audited – Automated Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023

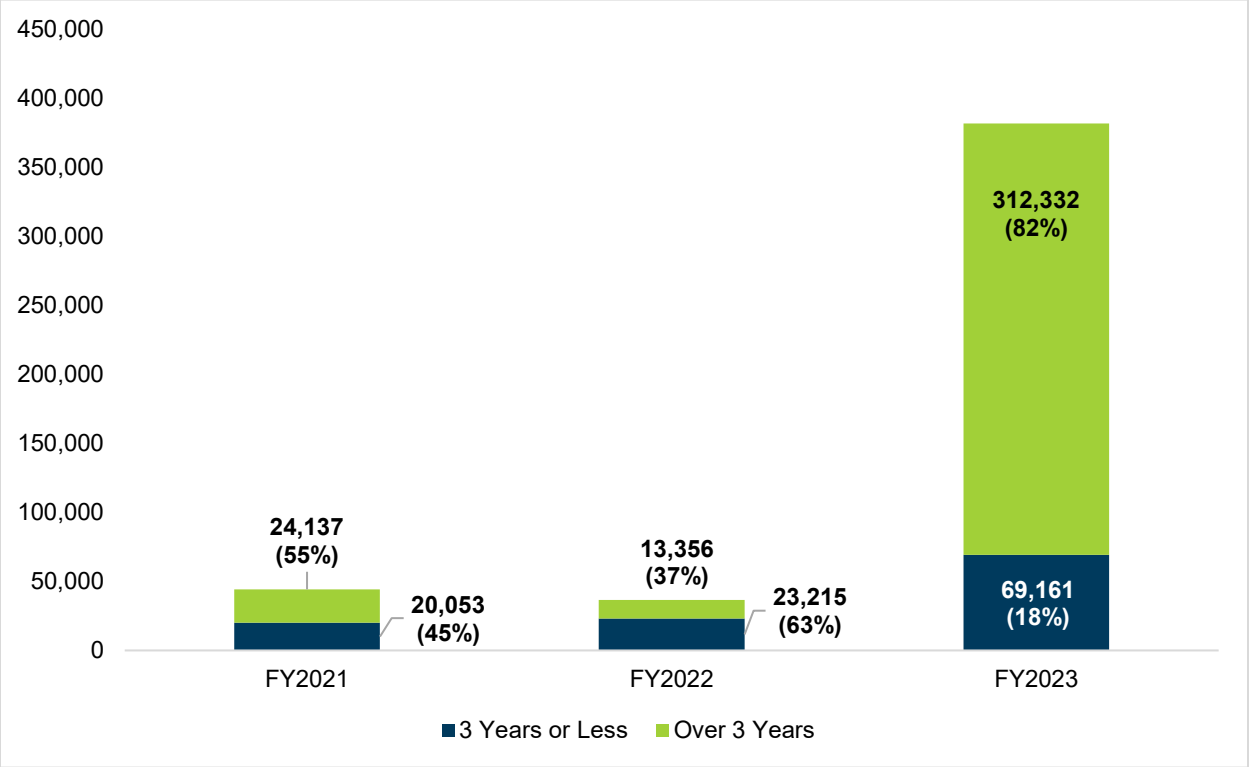
Exhibit 20: Dollar Value of Identified Overpayments – Automated Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023

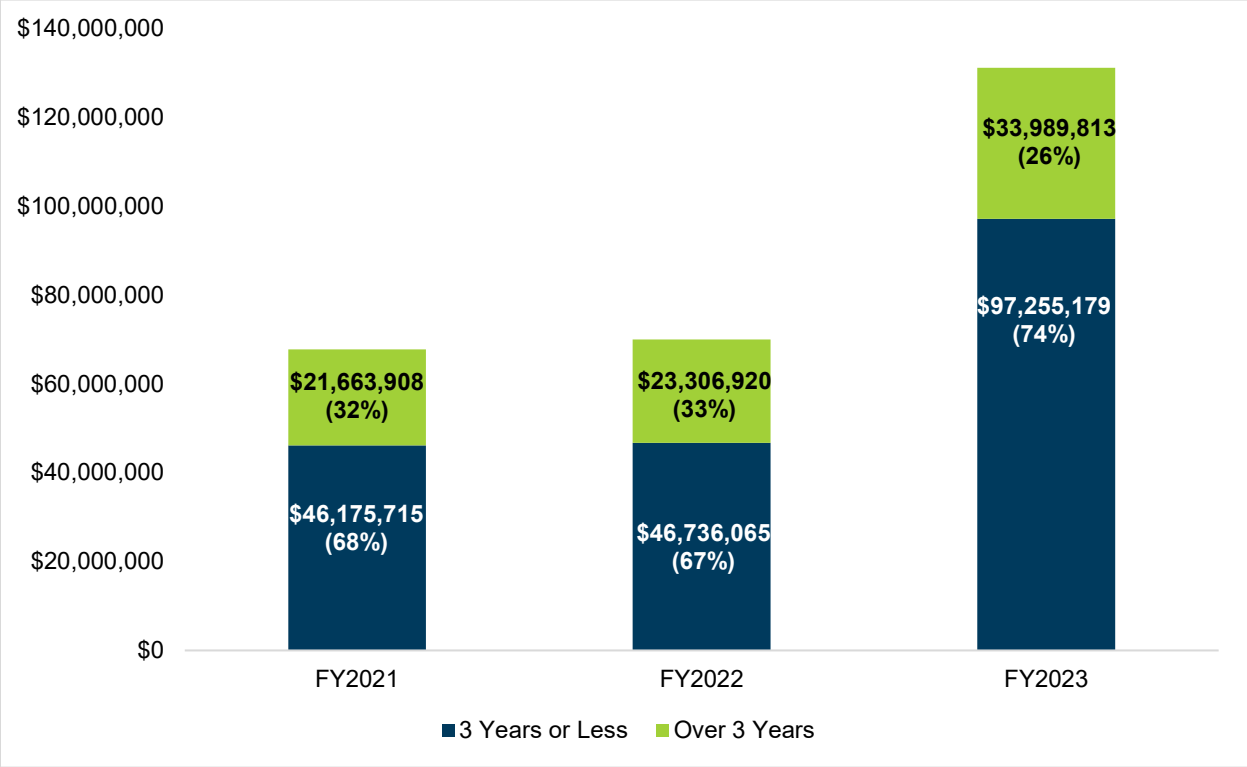
Exhibits 21 and **22** show our analysis with complex and automated audits combined and show that approximately one-third of the claims reviewed were from the most recent three-year period, and more than two-thirds of all identified overpayments in the past three years are from claims with a lookback period of less than three years.

Exhibit 21: Number of Claims - Automated and Complex Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023

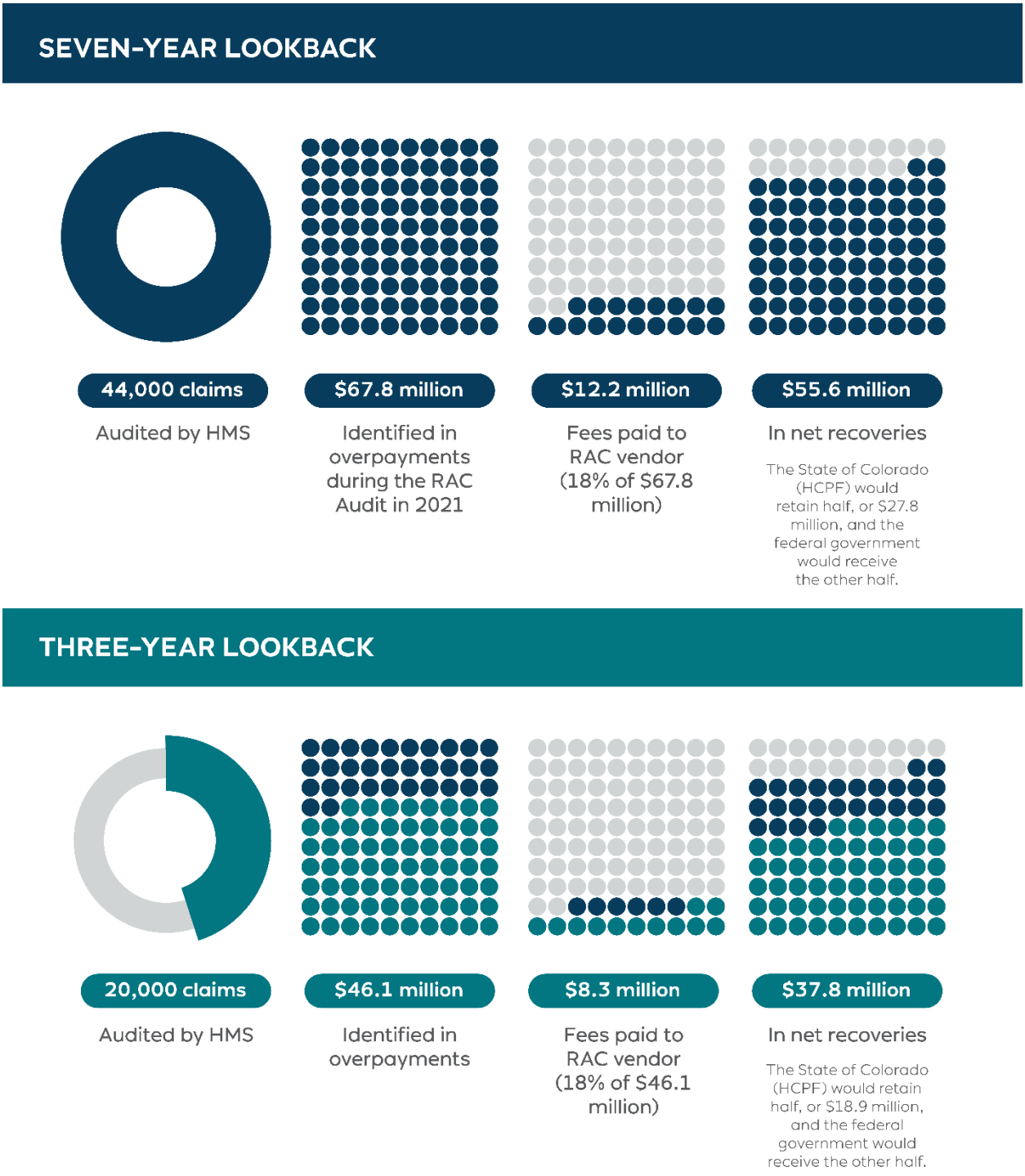
Exhibit 22: Dollar Value of Identified Overpayments - Automated and Complex Audits



Source: BerryDunn analysis of claims audited by HMS from January 1, 2021 to June 30, 2023.

Exhibit 23 below shows the potential financial impact of a change from a seven- to a three-year lookback period. The example uses actual figures from the RAC audits conducted in 2021 and estimates how the funds recovered and returned to the State would decrease from approximately $31 million to $22 million using a three-year lookback period. This assumes that changes to the RAC audits are not made, such as changes to scenarios, and the age of paid claims that are audited.

Exhibit 23: Recoveries under Seven-Year and Three-Year Lookback Periods



Source: BerryDunn analysis of claims audited by HMS in FY2021

The current RAC audit scenarios and audit approach were developed by HMS and HCPF with the seven-year lookback period in place. In the event that the lookback period was shortened, tailoring the scenarios and approach for a shorter lookback period would be reasonable and could help prevent the level of recoveries from dropping significantly due to looking back fewer

years. Modifications could include expanding the scope of complex reviews from the current focus on hospitals, hospice, and physician-administered drugs to more provider types and developing new automated audit scenarios to increase the review of claims in a three-year period, rather than a seven-year period. Developing new scenarios would incur development costs for HMS, and likely increase workload for HCPF staff. HCPF also stated that reducing the lookback period to three years would increase workload for HCPF staff responsible for administration of the RAC program, due to needing to process more audits simultaneously in order to maintain the same level of audits and recoveries if the audits were required to occur within three years of the “Claim Paid Date”.

Another change could be to include claims from the current year, which are now excluded because they are in their first year, which is considered to be the “timely filing period.” The timely filing period allows providers up to a year from the *Date of Service* to submit a claim for payment and to edit or correct a submitted claim, if needed. HCPF told us the reason it excludes claims in the timely filing period from RAC audits is to avoid reviewing claims that may be changed. There is no regulation or requirement that prohibits the auditing of claims within the timely filing period. Other payers, including Medicare and some other state Medicaid programs, also have a one-year timely filing period but perform RAC audits of claims in that period.

Policy Consideration - We do not provide a suggestion on the length of the lookback period for the Colorado RAC program, as this is a policy decision for the Department of Health Care Policy & Financing and the General Assembly. However, we do report the results of these analyses to provide decision-makers with detailed information on the lookback period and possible outcomes if the decision is made to make a change.

Policy Consideration F – Administrative Burden on Providers from the RAC Program

Statute directed us to assess the administrative burden on providers associated with undergoing RAC audits and "the impact of audits on provider participation and access to care." [Sections 25.5-4-301(3.7)(a)(V) and (a)(VII), C.R.S.] Provider administrative burden is, at the most basic level, the time and costs placed on providers to comply with RAC audit demands. However, there is not a standard metric to measure administrative burden imposed on providers through RAC audits, and each provider may perceive the onerousness of an audit differently. For example, one provider may view the time spent responding to a RAC audit as an unnecessary burden, while others may view it as simply a cost of doing business.

Regardless of varying perceptions, RAC audits do place demands on providers, requiring them to expend resources to submit required medical records; review audit findings and, in some cases, contest them; and repay overpaid amounts. To assess the administrative burden of RAC audits on providers, we conducted the following procedures and analyses:

- Obtained providers' perspectives through a survey and interviews.
- Analyzed the distribution of audits across provider types. Although RAC audits are not designed to affect all providers equally, reviewing audits by provider type provides an indicator of how the administrative burden is distributed throughout the population of Medicaid-enrolled providers.
- Assessed how HCPF avoids duplicative audits to minimize burden.
- Analyzed whether the burdens imposed by RAC audits have led to providers leaving the Medicaid program.

CMS has made efforts to reduce the administrative burden on providers in the Medicaid program. In its Final Rule implementing the federal law for state Medicaid RAC programs, CMS acknowledged the importance of minimizing the burden of these programs on providers. The Final Rule cites several regulatory requirements as features designed to limit provider burden resulting from RAC audits, including the three-year maximum lookback period [42 CFR § 455.508(f)], and federal requirements for states to set auditing limits within the RAC program. The State of Colorado received a waiver from CMS that permits the use of a seven-year lookback period.

Provider Perspectives on Administrative Burden

In our provider survey and interviews, we asked providers to submit documentation and written statements regarding the costs that they have incurred from being audited by the RAC program. We received quantified anecdotal estimates from seven providers but most lacked sufficient details to allow us to estimate a cost per audit, or per claim reviewed. However, some of the anecdotal information from providers gives their perspective on the time and cost that can be involved in a RAC audit, as follows:

- “Responding to an audit can range from $10 - $30,000.”
- “Depending on the audit, it can take a few minutes or a few days. I would average that it takes 45 minutes per account that we are researching and pulling documents for.”
- “Even the 500 charts audited so far have cost us probably conservatively over $150,000 in staff/physician/response/lost productivity.”
- “Our legal bills were $4,750 for this audit.”
- One hospital stated they are considering a software manager for their audits, which costs $100,000 and that their outside legal expenses have now exceeded $500,000.

Various aspects of a RAC program can affect the administrative burden providers experience, including how many audits they undergo and how extensive the audit is (e.g., how many claims per provider the audit reviews). These aspects are discussed later in this section.

Distribution of Burden Across Provider Types

We analyzed data to identify the frequency of RAC audits by provider type, to identify how the administrative burden is distributed throughout the population of Medicaid-enrolled providers. Our analysis shows that there is not an even distribution of audits across providers and provider types. This is appropriate given the nature of the RAC program, which is designed to audit providers based on the risk of improper claims being filed. However, a concentration of audits among a limited number of providers results in those providers experiencing a more significant burden than providers that are audited less.

We analyzed data for RAC audits conducted in Fiscal Years 2018 through 2023, which included claims paid between January 2014 and March 2023, to identify whether certain provider types are under- or over-represented in RAC audits when considering that provider type’s portion of claims paid by number and dollar value. Both the number of claims audited, and the dollar value of identified overpayments, can be drivers of administrative burden. The number of claims audited affects the staff time necessary to respond to audits; the amount of identified overpayments can influence whether a provider challenges a finding through the Informal Reconsideration or appeals processes, which add to the provider’s cost for the audit.

Exhibit 24 shows the percentage of claims audited, from highest to lowest, by provider type.

Exhibit 24: Claims Audited and Overpayments Identified by Provider Type

Provider Type	# of Claims Audited	# of Claims Paid	% of Paid Claims Audited	Identified Overpayments	Claim Payment Amounts	% of Payment Amounts Audited
Hospice	2,644	93,970	2.8%	$9,692,704	$394,487,075	2.5%
Psychiatric Residential Treatment Facility	29	1,138	2.5%	$2,322	$11,797,342	0.0%
Hospital - General	123,047	18,976,261	0.6%	$203,455,882	$6,058,420,792	3.4%
Supply	42,451	6,737,710	0.6%	$6,231,533	$1,291,359,211	0.5%
Clinic - Practitioner	275,055	61,157,662	0.4%	$16,636,181	$6,520,025,518	0.3%
Hospital - Mental	16	4,149	0.4%	$307,268	$18,039,433	1.7%
Audiologist	9	2,747	0.3%	$13,306	$666,105	2.0%
Community Clinic	356	128,590	0.3%	$89,322	$25,267,224	0.4%
Physician	801	359,413	0.2%	$46,245	$36,936,007	0.1%
Independent Laboratory	18,132	8,414,542	0.2%	$53,261,724	$787,959,543	6.8%
Ambulatory Surgical Center	564	285,534	0.2%	$192,850	$105,090,722	0.2%
Non-Physician Practitioner - Group	11,477	5,819,493	0.2%	$1,038,947	$886,831,701	0.1%
Pharmacy	3,329	2,397,017	0.1%	$418,049	$195,747,486	0.2%
Podiatrist	57	45,826	0.1%	$38,826	$3,617,272	1.1%
Clinic - Dental	37	74,609	<0.1%	$23,820	$12,448,492	0.2%
Osteopath	28	63,976	<0.1%	$2,746	$4,991,202	0.1%
Indian Health Services – Federally Qualified Health Center	14	38,558	<0.1%	$54,645	$16,666,172	0.3%

Provider Type	# of Claims Audited	# of Claims Paid	% of Paid Claims Audited	Identified Overpayments	Claim Payment Amounts	% of Payment Amounts Audited
Community Mental Health Center	85	279,082	<0.1%	$53,339	$78,651,036	0.1%
Nurse Practitioner	14	51,924	<0.1%	$950	$6,217,618	<0.1%
Optometrist	30	140,034	<0.1%	$2,450	$18,209,318	<0.1%
Substance Use Disorder - Clinics	4	21,790	<0.1%	$440	$4,955,968	<0.1%
Home & Community Based Services (HCBS)	3,148	18,318,918	<0.1%	$573,687	$8,381,044,719	<0.1%
Speech Therapist	12	106,018	<0.1%	$1,128	$14,268,978	<0.1%
X-Ray Facility	50	449,028	<0.1%	$8,627	$62,778,013	<0.1%
Home Health	605	6,475,202	<0.1%	$159,351	$3,698,156,802	<0.1%
Federally Qualified Health Center	414	7,294,807	<0.1%	$214,007	$1,378,582,751	<0.1%
Residential Child Care Facility	10	197,919	<0.1%	$921	$39,891,998	<0.1%
Family Planning Clinic	5	113,380	<0.1%	$1,384	$19,312,651	<0.1%
Case Manager	9	224,560	<0.1%	$933	$128,897,733	<0.1%
Dialysis Center	6	208,023	<0.1%	$2,029	$94,616,593	<0.1%
Rural Health Clinic	24	1,436,207	<0.1%	$1,775	$218,323,841	<0.1%
Nursing Facility	33	2,483,168	<0.1%	$70,892	$3,595,657,275	<0.1%
Rehabilitation Agency	14	1,856,099	<0.1%	$962	$179,789,774	<0.1%
24 other Provider Types	*0*	*13,606,721*	*0.0%*	*$0*	*$1,717,865,149*	*0.0%*
Total	**482,509**	**157,864,075**	**0.3%**	**$292,599,245**	**$36,007,571,516**	**0.8%**

Source: BerryDunn analysis of reports provided by HCPF for claims audited by HMS and claims paid by Colorado Medicaid from January 1, 2018 – June 30, 2023.

We also analyzed the RAC audits at the billing National Provider Identifier Number (NPI) level, in addition to the provider type analysis above. NPIs are unique numbers assigned to each provider and can be assigned to an individual provider, such as a physical therapist, or to a provider organization, such as a hospital. We performed this analysis to assess the distribution of RAC audits across the population of providers. We found that 3,403 providers were audited between January 1, 2018 and June 30, 2023. Among the 3,403 providers, 39% of the claims audited and 37% of the identified overpayment dollars were from 10 providers. For the complex audits, we found that 43% of the audited claims and 48% of the identified overpayment dollars were from 10 billing NPIs. For the automated audits, we found that 47% of the audited claims and 51% of the identified overpayment dollars were from 10 providers. None of the providers are included in the list of 10 providers for both complex and automated audits. This shows that less than 1% of the audited providers accounted for roughly 40% of the audit volume.

HCPF stated that in general the number of claims audited from a specific provider is proportionate to the provider's size, meaning the concentration of audits may be higher on certain large health care systems that operate multiple locations with high audit volume. Additionally, some of these large health care systems may use a centralized office to respond to RAC audits while other providers may have RAC audit letters sent to the location where the medical service was rendered.

The analysis further shows that hospitals account for the largest portion of identified overpayments, and also the largest portion of claims paid by Colorado's Medicaid program. HCPF stated this is due to the dollar value of hospital services generally being more expensive than services rendered by other provider types. Additionally, HCPF stated that hospital identified overpayment amounts are large due to Colorado not utilizing hospital pre-authorizations. We note that some hospitals would disagree with this assertion, who stated to us that they disagree with a large portion of HCPF's overpayment demands.

The largest providers are primarily larger hospitals and health care systems, that typically have more human and financial resources to respond to RAC audits than smaller providers, often including staff whose primary responsibilities include compliance and audit related functions. However, even three of the largest providers interviewed during this evaluation expressed frustration with the burden imposed on them by the number of medical records requested for RAC audits and the number of claims identified as overpayments that the providers had to analyze.

State Medicaid RAC audit programs are not designed to be proportionate to the population of providers; they select claims for audit based on a variety of risk factors, including the assessed risk of improper payments and avoiding duplication with other audit and review activities. However, from this data, it appears that certain provider types are inherently at higher risk of being selected for RAC audits than others due to HCPF's risk assessment of certain medical services and claim types being assessed as a higher priority for identifying and recovering overpayments. HCPF's risk assessment factors include, but are not limited to, analysis of historic overpayment frequencies for different medical services, and provider types, and consideration of CMS publications regarding which provider and claim types are higher risk.

Duplication of RAC Audits and Other Claims Reviews

Section 2.5.-4-301(3.7)(a)(VIII), C.R.S., required this evaluation to assess the duplication of "utilization management reviews and approvals" with RAC audit reviews. Federal regulations for Medicaid RAC programs require that states "coordinate the recovery audit efforts of their RACs with other auditing entities" and "not audit claims that have already been audited or that are currently being audited by another entity." [42 CFR § 455.506(c) and 508(g)]. This is one of several federal regulations that CMS indicated, in its Final Rule for Medicaid RAC programs, is intended to minimize the burden placed on providers due to RAC audits.

To determine if the RAC program is coordinating review efforts and not duplicating audits by other entities, we reviewed policies and procedures for HCPF's program integrity functions that involve both post-payment and pre-payment claims reviews, and the process HCPF and HMS use to select claims for RAC audits to ensure they exclude claims that are undergoing other reviews. We also reviewed a sample of 100 claims that had undergone RAC audits as part of our procedures outlined in Chapter 2, and interviewed 11 providers participating in recent RAC audits and four provider associations that chose to provide information for this evaluation. Finally, we interviewed HCPF staff to gain an understanding of the current processes, challenges, and procedures that help ensure claims audits are not duplicated.

We found that HCPF has procedures in place to prevent duplicate review of claims between the RAC and other types of reviews. First, the RAC contract prohibits duplicative reviews, stating:

- All of the following kinds of claims are excluded from this Contract: Claims that have previously been audited; claims under investigation for criminal or civil recovery actions; claims currently subject to reviews or audits by other contractors or entities; any claims identified by HCPF for any reason including, but not limited, to situations where an active investigation is occurring, and litigation is occurring related to a formal appeal. [1.3.3]

- Contractor shall not review claims that have already been audited or that are currently being audited by another entity. Excluded claims may include, but are not limited to, reviews conducted by HCPF's Program Integrity and Contract Oversight section or other HCPF staff or contractors; other Colorado state agencies; and federal agencies including CMS; Federal Medicaid Integrity Contractors (MIC); the Federal Payment Error Rate Measurement (PERM) project; and the Health and Human Services, Office of the Inspector General (HHS OIG). [Contract Section 1.4.5]

- In order to minimize the impact on the Provider Community, Contractor shall avoid situations where Contractor and another entity are working on the same claim or where fraud investigations or law enforcement actions are being contemplated or are underway. [Contract Section 1.15.5.1]

In addition, HCPF has an established process to identify claims that should be excluded from RAC audits. HMS must provide HCPF a list of all claims that HMS intends to include in a complex or automated audit and HCPF compares the list to information in its database of excluded providers and claims. This database includes claims, each of which has a unique

identification number, that are under review by another entity. HCPF notifies HMS if any claim on its list should be excluded from audit.

Through our review of the sample of 100 claims that had been audited by HMS, we found one claim involved in an automated RAC review for which the provider filed a request for Informal Reconsideration because the claim had been reviewed by the HHS OIG and the Medicaid Fraud Control Unit (MFCU) at the Colorado Office of the Attorney General. HCPF ultimately retracted the findings for this provider that involved claims that had also been under review by federal agencies and the MFCU.

We discussed this claim with HCPF, which said that, in some cases, its controls to prevent duplicative reviews are not 100% effective. HCPF said that, in this case, the MFCU and the federal agencies that had reviewed these claims did not assign a unique number to each claim. As a result, when HCPF checked claims HMS planned to audit, there was no matching identifier in the excluded database. HCPF noted that this is a challenge for all states' RAC programs, because there is no national claims number system. One way HCPF attempts to compensate for this gap in preventing audit duplication is by notifying other agencies, such as the MFCU, prior to the launch of a new RAC audit. HCPF lists the providers that will be included in the audit and asks to be notified if any of those providers are under review by the other agency.

Provider Disenrollment due to Administrative Burden

Statute required this evaluation to assess "the impact of audits on provider participation." [Sections 25.5-4-301(3.7)(a)(V) and (a)(VII), C.R.S.] To address this requirement, we obtained data from HCPF on provider disenrollments for since 2018.

We then reviewed information on providers subjected to a RAC audit at any time between January 2018 and June 2023, and on providers that disenrolled from Medicaid during that period. According to this information, there were 2,603 providers audited by the RAC and, of those, 29 voluntarily disenrolled from Medicaid.

HCPF does not maintain any information on the RAC program's impact on provider participation in Medicaid and does not track the reasons providers disenroll. To try to determine the reasons each of these 29 providers left the Medicaid program, we analyzed information attributed to the provider's NPIs, which is assigned to each provider by CMS. The NPI number is a unique identification number for HIPAA-covered health care providers and organizations and is used to track administrative and financial information about the providers' operations. The NPI database does not track disenrollment information specifically, but in some cases, it contains information, such as state of licensure, current address, and whether the provider is still active, that helped us determine why a provider disenrolled. In cases where we could not identify a disenrollment reason from the NPI database, we performed searches of other publicly available records, such as the HCPF provider directory to identify if the provider is still enrolled as part of a different practice, and the HHS OIG Excluded Providers list to identify whether the provider is no longer eligible for participation in federally funded health care programs.

Based on our reviews, we could find no information on why 9 of the 29 providers disenrolled. For the other 20 providers, the most common reasons for disenrollment were related to the following circumstances:

1. Acquisition of the practice that resulted in the practice's deactivation as a unique entity.
2. Practice/provider moved out of Colorado.
3. Disenrollment of part of a practice, or the provider is no longer affiliated with a larger practice.

We also found that 20 of the 29 providers that disenrolled were part of health care practices where the practice is still enrolled in Colorado Medicaid, but the individual provider (e.g., physician) is no longer participating in the Medicaid program

Thus, our analysis did not find any evidence that providers have disenrolled from Colorado Medicaid due to any aspect of the RAC program, including the administrative burden, the lookback period, or the contingency fee. However, as indicated above, there were significant limitations associated with our review due to the absence of any tracking of the causes of provider disenrollments.

We reviewed provider Medicaid enrollment statistics provided by HCPF from September 2021 – June 2023 and identified that provider enrollment in Colorado's' Medicaid program has increased consistently since 2021.Total provider enrollment increased from 88,791 in September 2021 to 107,829 in June 2023.

Policy Consideration for HCPF - Our reviews of the administrative burden of RAC audits on providers indicate that the Department of Health Care Policy & Financing appears to have effective processes to prevent duplicative audits of providers, but that there is the potential for a greater burden on a small number of provider types. Although we did not find any evidence that providers disenrolled from Colorado Medicaid due to RAC audits, HCPF may want to establish methods to track in more detail why providers voluntarily disenroll from Medicaid.

Response

Department of Health Care Policy & Financing

> The Department has tracking tools in place for the distribution of audits, however, provider disenrollment is not handled by the RAC program. This would require updating provider participation, enrollment requirements, and provider-submitted information in the context of disenrollment. While we are in agreement that these details would be extremely helpful to maintain and to build reporting and trending around, we will need to review the feasibility of the resources needed within the Provider Relations group, the changes to responsibilities for the Department, the claims system vendor, and for provider services at the Department, along with any other areas affected.

There is no documented correlation between the RAC program and provider disenrollments, however, any tracking for the Department would be helpful for all areas of policy, programs, or reporting.

Addendum: Although the analysis we conducted of the reasons providers left the Colorado Medicaid program indicated no correlation to RAC audits, the analysis was very limited because there is no systematic tracking of the reasons providers disenroll, by either HCPF or any other entity.

Policy Consideration G – Cost-Benefit Analysis of the RAC Program

Statute required us to "consider … how the state should evaluate the cost-benefit analysis to determine whether the … [RAC] program is striking the right balance between accountability and access to care." [Section 25.5-4-301(b)(II)(D), C.R.S.] To address this issue, we first asked HCPF if it had conducted a cost-benefit analysis of the program. HCPF stated that it performs an informal cost-benefit analysis each time it submits a budget request to increase FTE for the RAC program; in essence, the decision to request additional resources for the RAC program indicates that HCPF has concluded that the added cost is outweighed by the benefits the program produces. Aside from routine analyses associated with any budget request, HCPF has not attempted to prepare a cost-benefit analysis of the RAC program or to otherwise quantify the accountability provided through the RAC program or the risk that audits could drive providers out of Medicaid and, thereby, reduce access to care.

On the surface, Colorado's RAC program appears to be very cost beneficial, as shown in the simplistic analysis in **Exhibit 25**.

Exhibit 25: Quantified Costs and Benefits of the RAC Program – Fiscal Year 2023

Quantified Costs		Quantified Benefits	
HCPF RAC program costs	$405,000 [1]	Recoveries	$47,000,000
RAC Contractor Fee paid	$8,965,000		
Office of Administrative Courts cost	$233,000		
Total Quantified Cost	$9,603,000	Total Quantified Recoveries	$47,000,000

Source: Information provided by HCPF on RAC program costs and RAC fee. Information provided by the Colorado Department of Personnel & Administration on Office of Administrative Courts cost.

1 – HCPF RAC program costs include wages and benefits paid in FY23. This amount is shared 50/50 with the federal government. Colorado's share of the RAC program costs was approximately $202,608.

However, the analysis above does not account for costs and benefits that are not readily quantifiable. To develop a comprehensive cost-benefit analysis, monetary values would need to be assigned to all aspects of the program. For example, HCPF's cost for employing staff for the RAC program and for paying HMS are readily apparent, but it is much more difficult to put a dollar value on the burden experienced by providers involved in audits. Similarly, the value of funds recovered as a result of RAC audits is known, but the extent to which the audits lead to more efficiency in Medicaid billing and payments is neither tracked nor quantified.

Because a comprehensive cost-benefit analysis has not been conducted on the RAC program, decision-making about the program relies on analyses and estimates that are oversimplified. Notably, HCPF views the RAC program as cost-free to the State because recoveries each year far exceed the readily quantified costs, as shown in **Exhibit 25** above. However, this

perspective may lead to over-reliance on the program as a control measure instead of up-front controls and processes to prevent overpayments to begin with.

A comprehensive cost-benefit analysis would also need to factor in other variables, including the following.

Settlement of appeals. HCPF sometimes settles with providers that appeal RAC findings even if the finding was accurate. Settlements result in the State collecting less in repayment than the total identified as overpaid. Settlements generally reduce the cost to providers of repaying funds, but also create costs for the provider to engage in the appeals and settlement processes. Settlements also create costs for the State to direct resources to consider the appealed issues and to develop and negotiate settlement offers, in addition to the reduced amount repaid. A cost-benefit analysis should consider the costs associated with the exit conference, Informal Reconsideration, and appeals processes, which might include the potential cost of increased administrative burdens on providers. Identifying the costs associated with the provider dispute processes would also allow HCPF to better assess if the RAC program is properly balancing accountability and access to care. HCPF stated that many providers are bypassing the exit conference and Informal Reconsideration processes. A cost analysis may help HCPF identify the financial impact of the increased number of appeals caused by circumventing these preliminary dispute resolution methods. If the appeals process is too expensive and time consuming, some providers might choose to absorb the cost of the wrongly denied claim rather than appeal it. This could limit access to care for patients, as providers become less likely to submit claims for complex or expensive procedures if they are concerned about the cost of the appeals process. By tracking the frequency and cost of each dispute resolution option, HCPF can pinpoint areas for improvement and optimize the program's cost-effectiveness.

Efficiencies gained as a result of audits. In addition to post-payment reviews, such as RAC audits, that identify Medicaid overpayments for recovery, HCPF has pre-payment controls designed to prevent improper payments from occurring. RAC audits sometimes identify issues that can be corrected though added or strengthened pre-payment controls to prevent improper payments up front, thereby reducing the need for after-the-fact reviews. Similarly, audits can identify conflicts or a lack of clarity in policies and guidance, which can lead to improper billing. A cost-benefit analysis should consider the benefits gained by reducing the number of improper billings and payments by calculating the cost of implementing stronger pre-payment controls based on identified audit findings, versus the potential future cost savings from preventing those errors up front.

Working with HMS to update policy and guidance sources (e.g., provider billing manuals and provider bulletins) to provide clear, unambiguous direction for preparing and submitting claims would help providers bill more accurately and reduce the incidence of overpayments.

Colorado Senate Bill 18-266, which directed HCPF to implement cost-saving strategies for the Medicaid program, provided HCPF with the authority to perform preadmission reviews of hospital claims via an evidence-based hospital review program. Currently HCPF is not exercising its statutory authority to perform these preadmission reviews.

The FAQ published by CMS in December 2011 reflects the expectation that states will use RAC programs not only to recover improper payments, but also to improve payment accuracy from the front end. The FAQ states: “CMS anticipates working with States to ensure that any program vulnerabilities that are identified by Medicaid RACs are addressed through policy changes, MMIS edits, or other alternatives available to the States.” Further, HCPF’s RAC contract specifically requires HMS to notify HCPF of areas it finds in RAC audits where Medicaid policies or systems require changes.

Policy Consideration – The Department of Health Care Policy & Financing (HCPF) should assess its existing processes and revise them, if needed, to ensure that it places a priority on translating what is learned in RAC audits into improved front-end payment controls. This should, over time, reduce the number of improper claims initially submitted and paid, but does require HCPF to devote staff resources from other units within the Department to implement. However, preventing an improper payment is, ultimately, much more cost effective than recovering one, for both the state and providers.

Response

Department of Health Care Policy & Financing

> The Department agrees with this policy consideration. While we have policies, reporting, and documentation in place to ensure the policy area is aware of the audits, approves of them, and has the information and recommendation on how to best put in front-end edits, we are happy to revise the processes and make a more robust process for the future. We have already implemented some of these recommendations and we will continue to build both internal and external communications, tracking and reporting to maintain oversight of what RAC audits found, the trends, and the recommendations for policy staff at the Department.

Policy Consideration H – Payment Model and Percentage

Under federal regulations, states must compensate their RAC contractors on a contingency basis for overpayments identified and recovered. Federal regulations allow states to set their own rates, but only provide matching funds for a contingency fee rate of up to the maximum Medicare RAC rate (12.5% or 17.5% for recoveries of claims for durable medical equipment) unless a state is approved a higher rate through a State Plan Amendment (SPA) in accordance with 42 CFR § 455.510(b)(5). Federal regulations also require states to offer their RACs incentives for finding provider underpayments. [42 CFR § 455.510(c)(2)].

A variety of factors affect a state's ability to attract and retain a qualified RAC. Perhaps the most significant of these is the amount of overpayments the contractor can identify for recovery. Because of the contingency fee payment structure, the compensation paid to a RAC varies with amounts recovered. According to a U.S. Government Accountability Office (GAO) study of the Medicaid RAC program, issued in June 2023, there were 21 states that had not implemented RAC programs as of federal Fiscal Year 2021. This was due, at least in part, to the states' assessments that RAC audits would not generate sufficient recoveries for a contract to be lucrative enough to support the business model and risk associated with a RAC contract.

Further, according to HCPF, there can be significant financial risk for a RAC contractor when it first contracts with a state. RAC contractors must be willing and able to cover up-front implementation costs to provide RAC services, such as expenses to develop and implement state-specific data systems. RAC contractors are only paid after they have conducted audits that identified overpayments, and are paid on a contingency basis, meaning there is no minimum guaranteed compensation.

Although the ability or inability to secure a RAC contractor may be due primarily to the potential for recoveries, and not the contingency fee offered, this discussion focuses on the contingency fee due to the statutory direction for this evaluation. Specifically, the statute required us to examine "the level of payments sufficient to maintain a RAC contractor" and "other states' … financing mechanisms" for RAC contractors. [Sections 25.5-4-301(3.7)(a)(I), (b)(I), (b)(II)(A), and (b)(II)(E), C.R.S.].

HCPF's 18% Contingency Fee for Identifying Overpayments

Overall, we could not definitively conclude on whether HCPF's flat 18% contingency fee is the minimum rate necessary to retain a RAC contractor in Colorado or whether HCPF is statutorily prohibited from paying a RAC contractor to identify underpayments, as discussed in the following sections.

HCPF has an approved SPA to pay a maximum contingency fee to the RAC of 18% of overpayments recovered; under the RAC contract, HCPF is paying a guaranteed 18% fee to HMS. However, HCPF could not provide a documented rationale for establishing the 18% guaranteed fee, which is the highest among states with RAC programs. For the period of July 1, 2011, through July 1, 2021 (when the current RAC contract was executed), we reviewed

HCPF's solicitations for RAC services, its executed RAC contracts, and its approved SPAs and developed a timeline of these events, as illustrated in **Exhibit 26**. The exhibit shows that the contingency fee paid to the RAC contractor has increased over time, with the current 18% rate being implemented in 2020. In developing this timeline, we noted several concerns:

- HCPF began paying the 18% fee in 2020, in the midst of an existing contract with HMS. Because HCPF told us that the higher rate was needed to retain RAC services, we expected that the higher rate would be offered when HCPF was procuring a new RAC contract (most recently in 2021). The increase in contingency fee was communicated via Contract Transmittal #5 on October 15, 2020. The use of contract transmittals to adjust contract elements is discussed in Finding 3.
- HCPF's rationale for implementing the 18% rate in 2020 is based on several factors, including its experience and bidder comments in failed procurements of a RAC from 2013-2016. HCPF told us that, around mid to late 2020, HMS had implemented a new methodology to help identify fraudulent Medicaid payments and began conducting more complicated audits than in the past. HCPF increased the rate to 18% to compensate HMS for these activities. However, HCPF could not provide any documentation that it evaluated the need for those services, or their value to the state, as a basis for increasing the fee. Further, HCPF did not amend the RAC contract to state that the RAC contractor is required to provide these expanded services or to increase the contingency fee. Nor has HCPF evaluated the impact that a lower contingency fee, or a tiered structure, might have on costs and recovery rates. In addition, the rationale does not explain why HCPF changed the *structure* of the fee from a tiered maximum to a guaranteed flat rate. Until this change, the contract offered a base fee of 11% for automated audits and 14.5% for complex audits, with another 2.5% being added if the contractor met performance goals. HCPF now pays the flat fee of 18% for both automated and complex audits regardless of performance level.

Exhibit 26: Colorado RAC Vendor Contract Timeline

Time Frame	RAC Contract Situation	Contingency Fee
July 1, 2011 to June 30, 2013[1]	HCPF contracted with CGI Federal.	11% maximum for automated audits; 11% maximum for complex audits [4]
July 1, 2013 to June 30, 2016	Program suspended. HCPF issued several RFPs for RAC services without success. CMS approved suspension of the program for this period.	HCPF initially offered maximum fees of 7% for automated audits and 10% for complex audits. In a later RFP, it increased these to 11% and 14.5% respectively.
2015	HCPF requested and was approved by CMS to pay a maximum 18% RAC fee. Issued new RFP for RAC services.	13.5% maximum for automated audits; 17% maximum for complex audits
July 1, 2016 to June 30, 2021 [2]	HCPF contracted with HMS.	13.5% maximum for automated audits; 17% maximum for complex audits [4]
October 15, 2020	HCPF changed the fee structure and amount, effective for automated audits that began on or after October 15, 2020.	18% for automated and complex audits [5]
March 12, 2021	HCPF issued an RFP for RAC services.	Shall not exceed the maximum percentage rate of 18% of recovered overpayments.
July 1, 2021 to present [3]	HCPF executes a new contract with HMS.	18% for automated and complex audits

Source: BerryDunn analysis of RFPs, contracts, and SPAs.
1 – The 2011 contract was for a 1-year term with an option to extend annually for 4 years. HCPF exercised this option through June 30, 2013.
2 – The 2016 contract was for a 1-year term with an option to extend annually for 5 years. HCPF exercised this option through June 30, 2021.
3 - The 2021 contract was for a 1-year term with an option to extend annually for 5 years. To date, HCPF has exercised this option through June 30, 2024.
4 – In the periods HCPF paid a tiered rate, it had a base rate for automated audits and a base rate for complex audits, with added fees being available for both types if the contractor met or exceeded performance goals. The maximum rates cited in the exhibit combine the base rates with the performance rates. HCPF told us it has historically paid the maximums because contractors consistently met their goals.
5 – The 18% is paid for both automated and complex audits and is a guaranteed rate, rather than a maximum available based on the contractor's performance.

We collected information on the contingency fees in the other 17 states that had RAC programs as of December 2023 and found two states (besides Colorado) had CMS approval to pay their RACs contingency fees above the federal maximum of 12.5% to identify overpayments. Fees above the federal maximum may indicate that the federal maximum was viewed as insufficient in these states to retain qualified RACs. At the same time, 15 states pay fees to identify overpayments that are at or below 12.5%, meaning they have not seen the need for a

contingency fee above the federal maximum to retain a RAC contractor. In 10 of these 15 states, RAC services are provided by HMS, the same vendor that contracts with HCPF.

The rates each state pays its RAC to identify overpayments are shown in **Exhibit 27**.

Exhibit 27: Medicaid RAC Vendor Contingency Fees by State

State	RAC Vendor Fee for Overpayments	RAC Vendor
Colorado	18%	Health Management Systems, Inc.
Hawaii	17.5%	Myers and Stauffer, LLC
West Virginia	Above the federal maximum. Exact fee not provided.[2]	Health Management Systems, Inc.
Arizona, California, Connecticut, Illinois, Nevada, New Mexico, North Carolina, South Carolina	Federal maximum[1]	Health Management Systems, Inc.
Georgia, Minnesota	Federal maximum[1]	Myers and Stauffer, LLC
New York	Federal maximum[1]	Performant Financial Corporation
Mississippi	Federal maximum[1]	LaunchPoint Ventures dba Discovery Health Partners
Indiana	Federal maximum[1]	Family & Social Services Administration Audit Service
Texas	9 to 12.5% depending on the type of review (automated or complex)	Health Management Systems, Inc.
Oregon	12%	Health Management Systems, Inc.

Source: BerryDunn analysis of Medicaid RAC Vendor contingency fees by other states
1 – The federal maximum is 12.5% for all claims except those for durable medical equipment, which is 17.5%.
2 – We were unable to obtain the exact fee paid by West Virginia but it has a State Plan Amendment effective January 1, 2022 that allows it to use a RAC contingency fee that exceeds the federal maximum of 12.5%.

HCPF stated that Colorado's RAC program is a more complex, intensive, and robust program, and the length of audit and the number and quality of resources required for audits are in excess of what most states require for their RAC programs. In addition, HCPF stated that more services and staffing, plus a lengthy administrative appeals process requires a higher fee. Further, according to HCPF, Colorado has a higher appeals rate due to the formal appeal structure. Since the contract requires the RAC contractor to fulfill duties for appeals, this is reflected in the higher contingency fee. CMS rules state that the "potential length of a State's administrative appeals process may have an impact on the methodology or structure of the payment agreement between a State and a Medicaid RAC."

Over the last seven years, HCPF reported that the Colorado RAC program has recovered approximately $77.6 million in improper payments made to providers. Our research found that some states' RAC programs have a narrow focus, auditing only a few service types, and some

also conduct only automated audits. For example, some states' RAC programs review only a subset of Medicaid claims – such as dental claims– and some states conduct only automated reviews. As discussed in Chapter 4, we were unable to collect information from other states on the overpayment amounts identified through their RAC audits.

Compensating for Underpayments Identified

Federal regulations require state Medicaid RAC programs to include the identification of underpayments to providers. Specifically, 42 CFR § 455.506 (a) states that "Medicaid RACs will review claims submitted by providers … to identify underpayments" and, according to 42 CFR 455.510(c), "States must determine the fee paid to a Medicaid RAC to identify underpayments. States must adequately incentivize the detection of underpayments." However, states may be exempted from federal requirements that are not allowed in state law. HCPF's approved SPA exempts HCPF from the requirement to pay the RAC to identify provider underpayments. Based on our evaluation, HCPF is adhering to the SPA and does not provide any compensation to the RAC to identify underpayments. None of the RAC contracts has included payment to the RAC to identify provider underpayments. However, paying the RAC to identify underpayments so they can be corrected is a means by which HCPF could offer provider support and help offset the burden of audits.

For comparison purposes, we researched how other states compensate their RACs to identify underpayments to providers. We were unable to collect information from five states but **Exhibit 28** shows that at least 12 other states pay their RACs to audit for provider underpayments.

Exhibit 28: Medicaid RAC Fees to Identify Underpayments

STATE	FEE
California	10.5%
Colorado	0%
Connecticut	12.5%
Georgia	Hourly Fee
Hawaii	Hourly Fee
Illinois	12.5%
Indiana	12.5%
Minnesota	12.5%
New Mexico	12.5%
New York	5.25%
North Carolina	$30 Flat Fee
Oregon	Flat Fee
South Carolina	11.5%

HCPF requested an exception from CMS for paying its RAC to identify underpayments based on state statute (Section 25.5-4-301(3)(b), C.R.S), but without any legal analysis, such as guidance from the Attorney General's Office, on whether this is prohibited by statute. A plain reading of the statute does not clearly preclude compensating a contractor to identify improper

underpayments to providers. Specifically, Section 25.5-4-301(3)(b), C.R.S., states: "The state department is authorized to engage the services of a qualified agent … for the purpose of conducting a review or audit of a provider to assist in determining whether there has been an overpayment to a provider and the amount of that overpayment. … The state department is further authorized to enter into a contract with a qualified agent for the purpose of conducting a review or an audit of a provider that provides that the compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider." Although the statute provides specific authority to HCPF to execute a contingency-based contract to identify overpayments, it does not provide guidance with respect to whether HCPF can pay a contractor to identify underpayments.

Impact of the Payment Model

According to information HCPF provided, the contingency fee paid to HMS is 100% covered by federal funds; therefore, the level of the contingency fee has no direct impact on state funds.

Therefore, if the State is paying a vendor contingency fee that is higher than necessary this would reduce the net amount recovered from overpayments and subsequently returned to the federal government but would not affect state funds. If HCPF instituted a tiered rate, it would likely result in some savings to the federal government. For example, if HCPF had $50 million of overpayments recovered and used a 14% rate for automated reviews and maintained the 18% rate for complex reviews, we estimate the RAC payment would have been about $600,000, or 7%, lower than the $9 million it would have paid under the current flat rate of 18%. This represents a potential savings to the federal government.

With respect to not compensating the RAC to identify underpayments, if such compensation is allowable under state law, HCPF is missing opportunities to both improve the accuracy of Medicaid payments overall, by identifying and correcting underpayments as well as overpayments, and to improve relationships with providers, some of whom indicated in their responses to our provider survey that they view the RAC program as punitive rather than educational or geared toward improvement.

Policy Consideration for HCPF - The Department of Health Care Policy & Financing (HCPF) should consider evaluating the current RAC contingency fee amount and structure for identifying overpayments, including reviewing fees in other states, evaluating its needed services, and lowering the fee when feasible to ensure the compensation is reasonable but not excessive. HCPF should also consider seeking legal guidance, such as through the Attorney General's Office, on its authority to pay a contractor to find underpayments and, if legally allowable, establish a payment in accordance with federal regulations.

Response

Department of Health Care Policy & Financing

> The Department partially agrees with this recommendation. While we can review the national trends of RAC contingency-based contracts, our fees must reflect the contractual processes and the audit work associated with the HMS contract. Other state agreements are not fully parallel to the Colorado Medicaid RAC program. Further, the federal government (CMS)

pays the fees associated with the RAC program, not the state. CMS approves the appropriateness of the payment, as well as the RAC audit programs, thereby signing off on the appropriateness of the fee they are willing to pay for those programs. We are already working to make a national “workgroup” of RAC contract managers and program staff to help build those relationships and sharing of information. Through this process, we hope to share best practices, audit program features, outcomes, and fees. Regarding overpayments, HCPF will work through the adoption of policy changes in accordance with the evaluation recommendations, including learnings from other states that hold providers more accountable to properly complying with the RAC program. This will include self-auditing - which is a CMS provider guideline. That would give providers the opportunity to self-identify underpayments as well as overpayments. HCPF will also pursue the opportunity to identify underpayments more effectively, in addition to the above self-audit process.

Chapter 4: How Colorado's Recovery Audit Contractor Program Compares with Those in Other States

Although the federal requirement for state Medicaid agencies to establish Recovery Audit Contractor (RAC) programs generally applies to all states, states may request that the Centers for Medicare & Medicaid Services (CMS) exempt them from the requirement. As of December 2023, the following 18 states had active programs in place.

Exhibit 29: States with RAC Programs as of December 2023

#	RAC State		
1	Arizona	10	Mississippi
2	California	11	Nevada
3	Colorado	12	New Mexico
4	Connecticut	13	New York
5	Georgia	14	North Carolina
6	Hawaii	15	Oregon
7	Illinois	16	South Carolina
8	Indiana	17	Texas
9	Minnesota	18	West Virginia

Source: BerryDunn research on state Medicaid RAC programs.

Federal regulations allow states considerable flexibility in designing their RAC programs. Some program elements, such as the lookback period, must receive approval from CMS for the state to deviate from federal standards. Other program elements can be tailored by the state without CMS approval, such as the types of services to be included in audited claims (e.g., dental, mental health).

Statute required this evaluation to collect a variety of information on RAC programs in other states. Some information on other states is discussed in Chapters 2 and 3 of the report, such as the payment structure, contingency fee rates, and lookback period other states have established for their RAC programs. This chapter includes the limited statistical information we were able to collect from other states and detailed exhibits illustrating the scope and outcomes of RAC audits in Colorado over the last five years.

Statistics from Other States

To gather information from other states with RAC programs, we reviewed State Plan Amendments, reviewed information available on the websites of each of the Medicaid agencies for the 17 other state RAC programs; reviewed information on the websites of each of the RAC

organizations that are under contract with states; and requested information from a subset of eight state programs, including information related to their RAC program design, policies and procedures, and the statistics referenced above. We also interviewed five of these eight states for a better understanding of their programs.

In selecting the subset of eight states to contact as part of this evaluation, we considered the RAC vendor in each state, the lookback periods, and the contingency payment structure. The selection process was discussed with the Department of Health Care Policy & Financing (HCPF) prior to reaching out to the states individually.

We initially contacted each of the eight states by email to explain the reason for the contact, describe the data we sought, and provide the statutory requirements underlying the requests. About half of the states responded to our initial emails, but for the other states, we sent multiple follow-up emails and/or called to try to speak to someone directly to solicit the highest number of responses. Ultimately, we were able to interview five states and obtain very limited statistics from one of the five. The following is a list of the states we contacted and the results of our efforts:

- South Carolina – initial email, interviewed, limited data provided.
- Georgia – initial email, interviewed, no data provided.
- Oregon – initial email, follow-up email, interviewed, no data provided.
- New York – initial email to multiple contacts, interviewed, follow-up email sent to interview contact requesting statistics, no response received.
- Texas – initial email to multiple contacts, called, interviewed, no data provided.
- New Mexico – initial email, follow-up email, called, no response received.
- North Carolina – initial email, follow-up email, emailed Health Management Systems, Inc. (HMS) contact, no response received.
- West Virginia – initial email, follow-up email, called, no response received.

Initially, we requested all of the statistics the statute asked for, including the proportion and dollar value of claims subject to audit, the proportion of claims that resulted in RAC recoveries, and the number of claims appealed in the past five years. The states that responded to this request all indicated they could not or would not provide this information to us. We then reduced the request to include any period of time less than five years but got the same response. Finally, we asked if states could provide any of the statistics we were seeking, including high-level summary statistics, such as those they may compile for their own reporting. Only one state, South Carolina, agreed to provide limited statistics related to their RAC program. Other states told us they would not provide the data due to concerns over the sensitivity of the data and/or the time and resources it would take to collect the information. In addition, some states never replied to our emails or calls. Since there were several limitations to the data provided by South Carolina, it was not comparable to the data provided by Colorado. A key difference between South Carolina and Colorado is that South Carolina had only two approved audit scenarios and

conducted only complex audits; Colorado has over 30 approved audit scenarios and conducts both automated and complex audits. Also, South Carolina started conducting RAC audits in 2022 and paused them in January 2023, so the data provided was for only one year.

Colorado RAC Statistics

We analyzed data from HCPF to quantify RAC audits conducted in Colorado in Fiscal Years 2018 through 2023. Colorado state Fiscal Years run from July 1 through June 30 each year. The primary goal was to compile statistics from Colorado that could be compared with the same data from other states. Although we were unable to obtain comparable data from other states, the exhibits in this section provide the results of our analysis of Colorado data.

Statute specifically directed this evaluation to examine the following statistics for Colorado's RAC program, and, to the extent feasible, disaggregate them [Section 25.5-4-301(3.7)(a)(IV), C.R.S]. This section presents our analysis for each of these required data points:

1. Statistic #1 – the number, proportion, and value of claims audited, relative to total potential claims subject to the RAC program.
2. Statistic #2 – the number, proportion, and value of recoupments.
3. Statistic #3 – the number, proportion, value, and result of contested audit findings with their disposition status.
4. Statistic # 4 – the number, proportion, and value of findings that were discussed in exit conferences.
5. Statistic #5 – the number and proportion of providers impacted by claim audits.
6. Statistic # 6 – the number and proportion of providers that contested audit findings.

According to HCPF, it began implementation of a new claims system in 2017, which has made it time consuming and costly to retrieve data on claims paid before 2014. As a result, HCPF told us it did not include any claims paid before 2014 in RAC audits once it resumed the RAC program in mid-2016 (after having suspended the program, with CMS approval, between July 2013 and June 2016). This means that, until 2021, the lookback periods were less than seven years because, in each earlier year, the audits only included claims that were paid as far back as 2014. HCPF also told us that it could not reasonably provide us with claims data prior to 2014; it provided us data for claims paid from January 2014 through March 2023. Due to this limitation, in the exhibits in this chapter, data for Fiscal Years 2018, 2019, and 2020 reflect less than the full seven-year lookback period.

Statistic #1 - Number, Proportion, and Value of Claims Audited in the RAC Program

Exhibit 30 provides an analysis of the number and proportion of paid claims that were audited by Fiscal Year. For each Fiscal Year, the "Total Number of Claims Paid" column is the number of claims that were paid within the lookback period for that year. For example, for Fiscal Year 2022, there were approximately 128 million Medicaid claims totaling approximately $30.9 billion that had been paid within the seven-year lookback period (i.e., back to 2015) that could have been selected for a RAC audit.

Exhibit 30: Claims Paid and Audited by Fiscal Year

FY[1]	Total # of Claims Paid Subject to Audit (in millions)	Total # and Percentage of Claims Audited		Total Dollar Value of Claims Paid Subject to Audit	Total Value (in millions) and Percentage of Value of Claims Audited	
2018	88.2	1,128	<0.0001%	$17,860,046,861	$1.4	0.01%
2019	98.0	5,042	<0.0001%	$21,024,714,261	$6.5	0.03%
2020	112.6	14,085	0.0001%	$25,402,926,200	$15.5	0.06%
2021	121.2	44,190	0.0004%	$28,096,351,461	$67.8	0.24%
2022	128.0	36,571	0.0003%	$30,899,945,704	$70.0	0.23%
2023	136.4	381,493	0.0003%	$34,562,437,183	$131.2	0.38%

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower figures for number of claims paid and dollar value of claims paid than in later years.

Statistic #2 - Number, Proportion, and Value of Audited Claims Identified as Having Overpayments

There are inherent differences between automated and complex audits in the proportion of audited claims that are identified as having overpayments. Automated audits typically identify overpayments in the majority of claims audited because they are essentially queries of all paid claims in the lookback period to find obvious improper payments. An example of a payment that is obviously improper is one made on a claim where the provider billed for providing a certain service multiple times to one patient in one day, when Medicaid policies only allow a single such service for one patient in one day. Complex audits have a lower proportion of identified overpayments, due in large part to the fact that clinical judgment may have been involved in both the provider's decision about the services it needed to provide and the HMS auditor's determination of whether the claim is fully documented and justified. These differences are illustrated in **Exhibit 31**, which includes a breakdown of all claims from automated and complex audits that had claims identified as overpayments.

Exhibit 31: Claims Audited with Overpayments Identified by Fiscal Year

FY[1]	# of Automated Audit Claims	# of Automated Audit Claims with Identified Overpayments	Percentage of Automated Audit Claims with Identified Overpayments	# of Complex Audit Claims	# of Complex Audit Claims with Identified Overpayments	Percentage of Complex Audit Claims with Identified Overpayments
2018	147 [1]	147	100%	981	340	34.7%
2019	835 [1]	833	99.8%	4,207	1,681	40.0%
2020	2,286 [1]	2,280	99.7%	11,799	3,590	30.4%
2021	20,336	20,290	99.8%	23,854	9,831	41.2%
2022	19,946	19,901	99.8%	16,625	6,131	36.9%
2023	339,934	339,883	100%	41,559	19,310	46.5%

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower figures for number of claims audited than in later years.

Statistic #3 - Number, Proportion, Value, and Result of RAC Audit Findings Contested by Providers

Providers have two methods to contest RAC audit findings – Informal Reconsiderations and appeals – and have the option to use either method, or both. See Chapter 1 for more detail on how appeals and Informal Reconsiderations are processed by HMS and HCPF. **Exhibit 32** shows the number and proportion of claims with findings (i.e., identified overpayments) that were contested through an Informal Reconsideration or appeal. The exhibit separates data for automated and complex audits.

Exhibit 32: Number and Proportion of Contested Claims by Fiscal Year

FY[1]	Automated Audits					Complex Audits				
	# of Claims with Findings	Claims with IR Requested		Claims Appealed		# of Claims with Findings	Claims with IR Requested		Claims Appealed	
		#	%	#	%		#	%	#	%
2018	147	22	14.9	0	0	340	229	67.4	157	46.2
2019	833	73	8.8	59	7.1	1,681	1,078	64.1	565	33.6
2020	2,280	86	3.8	35	1.5	3,590	2,807	78.2	1,383	38.5
2021	20,290	2,637	13.0	1,982	9.8	9,831	6,725	68.4	3,963	40.3
2022	19,901	5,966	30.0	2,667	13.4	6,131	3,868	63.1	1,791	29.2
2023	339,883	73,578	21.6	31,259	9.2	19,310	9,649	50.0	3,222	16.7

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower figures for number of claims with findings than in later years.

Exhibit 33 includes a breakdown of all automated and complex audits with audited claims for which the provider requested an Informal Reconsideration or filed an appeal and the outcomes. Providers can request either, or both, and are not required to request an Informal Reconsideration before proceeding to appeal. As such, we show the Informal Reconsiderations separate from appeals. Appeals that are not settled are either still open, were withdrawn, or were disregarded. Disregarded appeals occur when HCPF determines that an appeal will not need to be fully processed. For example, HCPF will disregard appeals if it is going to implement a global settlement or rescind all claims in specific situations.

Exhibit 33: Informal Reconsideration and Appeal Information by RAC Audit Type and Fiscal Year

Automated Audits							
	Informal Reconsiderations				Appeals		
FY [2]	# of Claims with IR [1] Requested	# of Claims with Finding Upheld	% Upheld		# of Claims Appealed	# of Claims Settled	% Settled
2018	22	22	100%		0	0	N/A
2019	73	72	98.6%		59	20	33.9%
2020	86	80	93.0%		35	0	0%
2021	2,637	2,591	98.3%		1,982	0	0%
2022	5,966	5,921	99.2%		2,667	1,668	62.5%
2023	73,578	33,798	45.9%		31,259	0	0%
Total	**82,362**	**42,484**	**51.6%**		**36,002**	**1,688**	**4.7%**
Complex Audits							
	Informal Reconsiderations				Appeals		
FY	# of Claims with IR Requested	# of Claims with Finding Upheld	% Upheld		# of Claims Appealed	# of Claims Settled	% Settled
2018	229	207	90.4%		157	112	71.3%
2019	1,078	909	84.3%		565	135	23.9%
2020	2,807	2,143	76.3%		1,383	573	41.4%
2021	6,725	5,463	81.2%		3,963	726	18.3%
2022	3,868	3,118	80.6%		1,791	3	0.2%
2023	9,649	7,956	82.5%		3,222	0	0.0%
Total	**24,355**	**19,796**	**81.3%**		**11,081**	**1,549**	**14%**

Source: BerryDunn analysis of audited claims data provided by HCPF

1 – IR: Informal Reconsideration.

2 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower figures for number of claims paid and dollar value of claims paid than in later years.

Statistic # 4 – Number, Proportion, and Value of Findings Discussed in Exit Conferences

Under statute, providers may request a meeting, referred to as an exit conference, to discuss the results once a RAC audit is completed. Exit conferences are only offered for complex audits, and only occur upon provider request. The data shows that during our review period, providers requested exit conferences for about 30% of claims audited.

Exhibit 34 includes information about audited claims where an exit conference was requested.

Exhibit 34: Total Claims With Exit Conferences Held by Fiscal Year

FY [1]	# of Complex Claims Audited	# of Claims with Exit Conferences	Percentage of Claims with Exit Conferences	Dollar Value of Claims Audited (in millions)	Dollar Value of Claims with Exit Conferences (in millions)	Percentage of Value of Claims with Exit Conferences
2018	981	227	23.1%	$1,389,146	$240,088	17.3%
2019	4,207	799	19.0%	$6,418,482	$918,798	14.3%
2020	11,799	3,349	28.4%	$15,273,674	$5,163,620	33.8%
2021	23,854	7,149	30.0%	$49,403,643	$14,643,856	29.6%
2022	16,625	5,911	35.6%	$33,616,911	$11,536,477	34.3%
2023	41,559	11,700	28.2%	$96,736,335	$27,886,569	28.8%
Total	**99,025**	**29,135**	29.4%	$202,838,192	$60,389,409	29.8%

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower figures for number of claims and dollar value of claims audited than in later years.

Statistics #1 through #3 - Disaggregated

Statute asked for the RAC program statistics to be disaggregated, to the extent possible, by dates of service, audit finding date, and provider type. Audited claims are not tracked by the date of the service, but rather by the date of payment. However, the payment date can serve as an indicator of the time that can elapse between the date a service is provided and the date the associated claim is audited.

Exhibits 35 through 40 provide information on the proportion of claims audited each Fiscal Year, between 2018 and 2023, and approximately how much time passed between the payment and the audit. For example, in **Exhibit 35**, which shows the RAC audits conducted in Fiscal Year 2018, there were 43 audited claims that had been paid in 2015 (see green highlighted row and column). Since providers have a year after providing a service to bill Medicaid (this year being referred to as the Timely Filing Period), claims paid in 2015 include services provided as long as a year before the payment. In other words, the 43 audited claims could have included services that occurred as early as January 2014, if the provider waited until the end of the Timely Filing Period to submit or adjust the claim. Thus, some of the services that had claims paid in 2015 could have been provided as long as four years before the 2018 audit.

Exhibit 35 shows the number and dollar value of claims audited and eligible for audit during Fiscal Year 2018; 0.002% of eligible claims were audited, amounting to 0.01% of the total dollar value of claims.

Exhibit 35: Total of Individual Claims and Dollar Value Subject to 2018 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2018 [1]	Total Number of Claims Subject to Audit (in millions)	Total Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2017	13.9	$3,608,430,375	44	-	44	$6,196	$-	$6,196
2016	13.2	$2,624,101,527	47	-	47	$5,457	$-	$5,457
2015	16.4	$3,254,606,393	42	1	43	$4,249	$6,707	$10,956
2014	14.7	$2,838,089,304	14	980	994	$1,296	$1,382,439	$1,383,736
Total	**58.3**	**$12,325,227,599**	**147**	**981**	**1,128**	**$17,199**	**$1,389,146**	**$1,406,345**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF

1 – Due to the change in HCPF's claims system, for Fiscal Year 2018 the lookback period was 4 years.

Exhibit 36 shows the number and dollar value of claims audited and eligible for audit during Fiscal Year 2019. Based on the data in the exhibit, 0.007% of eligible claims were audited, amounting to 0.038% of the total dollar value of claims.

Exhibit 36: Total of Individual Claims and Dollar Value Subject to 2019 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2019	Number of Claims Subject to Audit (millions)	Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2018	18	$4,660,060,331	68	-	68	$6,696	$-	$6,696
2017	13.9	$3,608,430,375	200	-	200	$20,173	$-	$20,173
2016	13.2	$2,624,101,527	273	444	717	$34,083	$765,654	$799,737
2015	16.4	$3,254,606,393	199	2,698	2,897	$21,778	$4,136,693	$4,158,472
2014	14.7	$2,838,089,304	95	1,065	1,160	$9,101	$1,516,134	$1,525,236
Total	**76.2**	**$16,985,287,930**	**835**	**4,207**	**5,042**	**$91,832**	**$6,418,482**	**$6,510,314**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF

1 – Due to the change in HCPF's claims system, for Fiscal Year 2019 the lookback period was 5 years.

Exhibit 37 shows the number and dollar value of claims audited and eligible for audit during Fiscal Year 2020. Based on the data in the exhibit, 0.01% of eligible claims were audited, amounting to 0.07% of the total dollar value of claims.

Exhibit 37: Total of Individual Claims and Dollar Value Subject to 2020 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2020 [1]	Number of Claims Subject to Audit (millions)	Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2019	24.7	$6,218,993,927	53	218	271	$7,329	$331,682	$339,011
2018	18	$4,660,060,331	254	705	959	$34,205	$946,797	$981,002
2017	13.9	$3,608,430,375	479	1,963	2,442	$70,527	$2,657,129	$2,727,656
2016	13.2	$2,624,101,527	735	8,889	9,624	$90,781	$11,276,065	$11,366,846
2015	16.4	$3,254,606,393	605	23	628	$56,570	$62,001	$118,572
2014	14.7	$2,838,089,304	160	1	161	$21,898	$-	$21,898
Total	**101**	**23,204,281,857**	**2,286**	**11,799**	**14,085**	**$281,310**	**$15,273,674**	**$15,554,985**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF

1 – Due to the change in HCPF's claims system, for Fiscal Year 2020 the lookback period was 6 years.

Exhibit 38 shows the number and dollar value of claims audited and eligible for audit during Fiscal Year 2021. Based on the data in the exhibit, 0.04% of eligible claims were audited, amounting to 0.24% of the total dollar value of claims.

Exhibit 38: Total of Individual Claims and Dollar Value Subject to 2021 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2021	Number of Claims Subject to Audit (millions)	Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2021	21.6 [1]	$5,641,683,547 [1]	4	-	4	$ 3,457	$-	$ 3,457
2020	20.2	$4,892,069,604	1,417	3,581	4,998	$3,881,200	$7,075,728	$10,956,928
2019	24.7	$6,218,993,927	3,806	8,289	12,095	$7,499,651	$21,395,122	$28,894,773
2018	18	$4,660,060,331	3,045	3,289	6,334	$4,234,196	$5,868,331	$10,102,527
2017	13.9	$3,608,430,375	3,135	4,690	7,825	$1,234,046	$8,824,776	$10,058,822
2016	13.2	$2,624,101,527	5,296	3,989	9,285	$1,114,448	$6,209,515	$7,323,963
2015	16.4	$3,254,606,393	3,433	16	3,449	$423,355	$30,172	$453,527
2014	14.7	$2,838,089,304	200	-	200	$45,625	$-	$45,625
Total	**121.2**	**28,096,351,461**	**20,336**	**23,854**	**44,190**	**$18,435,979**	**$49,403,643**	**$67,839,622**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF.

1 - The total number and dollar value of claims subject to audit only includes the Fiscal Years within the seven-year lookback period. Claim amounts and dollar values in red are not included in the totals.

Exhibit 39 shows the number and dollar value of claims audited and eligible for audit during Fiscal Year 2022. Based on the data in the exhibit, 0.03% of eligible claims were audited, amounting to 0.23% of the total dollar value of claims.

Exhibit 39: Total of Individual Claims and Dollar Value Subject to 2022 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2022	Number of Claims Subject to Audit (millions)	Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2022	24.7 [1]	$6,917,097,872 [1]	13	-	13	$8,444	$-	$8,444
2021	21.6	$5,641,683,547	1,528	9,566	11,094	$455,107	$20,803,534	$21,258,641
2020	20.2	$4,892,069,604	4,458	5,663	10,121	$9,577,369	$9,862,365	$19,439,734
2019	24.7	$6,218,993,927	3,761	864	4,625	$14,336,696	$1,853,222	$16,189,917
2018	18	$4,660,060,331	3,510	58	3,568	$7,259,113	$141,083	$7,400,196
2017	13.9	$3,608,430,375	3,022	136	3,158	$2,959,538	$269,685	$3,229,223
2016	13.2	$2,624,101,527	2,646	334	2,980	$1,474,008	$680,359	$2,154,366
2015	16.4	$3,254,606,393	1,005	4	1,009	$349,185	$6,664	$355,849
2014 [2]	14.7 [1]	$2,838,089,304 [1]	3	-	3	$6,615	$-	$6,615
Total	**128**	**$30,899,945,704**	**19,946**	**16,625**	**36,571**	**$36,426,075**	**$33,616,911**	**$70,042,986**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF

1 - The total number and dollar value of claims subject to audit only includes the Fiscal Years within the seven-year lookback period. Claim amounts and dollar values in red are not included in the totals.

2 - Providers for three claims paid in June 2014 were sent letters notifying them of the claim audit in July 2022, which is outside of the seven-year lookback period.

Exhibit 40 shows the number and dollar value of claims audited and eligible for audit during the 2023 RAC Fiscal Year. Based on the data in the exhibit, 0.28% of eligible claims were audited, amounting to 0.38% of the total dollar value of claims.

Exhibit 40: Total of Individual Claims and Dollar Value Subject to 2023 RAC Audit by Fiscal Year

Years Subject to Audit in FY 2023	Number of Claims Subject to Audit (millions)	Dollar Value of Claims Subject to Audit	Claims Audited By Method			Dollar Value Audited By Method		
			Automated	Complex	Total	Automated	Complex	Total
2023	1.4 [1]	$465,176,589.45 [1]	220	-	220	$262,522	$-	$262,522
2022	24.7	$6,917,097,872	7,042	20,930	27,972	$4,103,000	$47,963,626	$52,066,627
2021	21.6	$5,641,683,547	13,150	16,855	30,005	$2,229,704	$38,386,085	$40,615,789
2020	20.2	$4,892,069,604	31,008	673	31,681	$6,316,392	$2,548,157	$8,864,550
2019	24.7	$6,218,993,927	43,929	1,072	45,001	$4,387,700	$2,934,205	$7,321,905
2018	18	$4,660,060,331	127,250	824	128,074	$8,500,679	$2,171,016	$10,671,695
2017	13.9	$3,608,430,375	102,348	713	103,061	$6,800,935	$1,581,332	$8,382,266
2016	13.2	$2,624,101,527	14,987	492	15,479	$1,907,724	$1,151,913	$3,059,638
Total	**136.4**	**$34,562,437,183**	**339,934**	**41,559**	**381,493**	**$34,508,656**	**$96,736,335**	**$131,244,992**

Source: BerryDunn analysis of claims subject to audit and claims audited data provided by HCPF

1 - The total number and dollar value of claims subject to audit only includes the Fiscal Years within the seven-year lookback period. Claim amounts and dollar values in red are not included in the totals.

2 - The FY 2023 data includes January – June 2023.

Statistic # 5 - Number and Proportion of Providers Affected by RAC Audits

Exhibits 41 through 44 include information on the number and types of providers that underwent RAC audits between 2018 and 2023.

Exhibit 41 quantifies the number of unique providers by provider NPI per Fiscal Year that had claims that were audited. This data is disaggregated by automated and complex audit types. The provider count is unique within each RAC Fiscal Year; however, the same providers may be included in multiple Fiscal Year's and within both audit types (automated and complex) for each Fiscal Year.

Exhibit 41: Total of Providers Audited by Fiscal Year

FY [1]	# of Providers With Automated Audit Claims	# of Providers With Complex Audit Claims	Total # of Providers Audited
2018	17	39	56
2019	145	136	281
2020	185	344	526
2021	866	204	1,068
2022	472	146	569
2023	1,934	607	2,316

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower number of providers audited than in later years.

Exhibits 42 and **43** show the same information as in **Exhibit 41** but disaggregate the data by provider type. As these exhibits show, 71.7% of automated audit claims audited in Fiscal Years 2018 through 2023 pertained to Clinical Practitioners, representing the largest share by provider type. However, Clinical Practitioners accounted for only 17.9% of automated audit claims by dollar value. Independent Laboratories accounted for the largest proportion of automated audit claims by dollar value with 59.3%, while they represented only 4.7% of automated audit claims. This indicates that the Clinical Practitioner claims were relatively low in dollar value while Independent Laboratories claims were relatively high in dollar value.

Exhibit 42: Number of Automated Audit Claims by Provider Type and RAC Fiscal Year

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Ambulatory Surgical Center		4	4		195	361	564	0.15%
Audiologist						9	9	0.00%
Case Manager						9	9	0.00%
Clinic – Dental						33	33	0.01%
Clinic – Practitioner	134	757	751	4,714	2,514	265,931	274,801	71.7%
Community Clinic						356	356	0.09%
Community Mental Health Center					12	25	37	0.01%
Family Planning Clinic					2		2	0.00%
FQHC				26		358	384	0.10%
HCBS						3,146	3,146	0.82%
Home Health						605	605	0.16%
Hospital – General			4		1,021	26,462	27,487	7.17%
Hospital – Mental						13	13	0.00%
Independent Laboratory				3,930	11,460	2,742	18,132	4.73%
Non-Physician Practitioner – Group		23	59	90	90	11,188	11,450	2.99%
Nurse Practitioner				4	9	1	14	0.00%
Nursing Facility					3	30	33	0.01%
Optometrist				12	6	12	30	0.01%
Osteopath	13		14	1			28	0.01%
Pharmacy			489	1,265	806	594	3,154	0.82%
Physician		44	55	105	67	530	801	0.21%
Podiatrist		7		12		38	57	0.01%
Psychiatric Residential Treatment Facility						29	29	0.01%
Rehabilitation Agency						14	14	0.00%

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Residential Child Care Facility						10	10	0.00%
Rural Health Clinic				14		10	24	0.01%
Speech Therapist						12	12	0.00%
Substance Use Disorder – Clinics						4	4	0.00%
Supply			910	10,163	3,761	27,362	42,196	11.00%
X-Ray Facility						50	50	0.01%
Total	147	835	2,286	20,336	19,946	339,934	383,484	

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower number of providers audited than in later years.

Exhibit 43: Dollar Value of Automated Audit Claims by Provider Type and Fiscal Year

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Ambulatory Surgical Center		$1,600	$2,326		$55,664	$133,260	$192,850	0.21%
Audiologist						$13,306	$13,306	0.01%
Case Manager						$933	$933	0.00%
Clinic – Dental						$10,278	$10,278	0.01%
Clinic – Practitioner	$15,971	$83,202	$82,553	$396,811	$188,957	$15,288,616	$16,056,110	17.9%
Community Clinic						$89,322	$89,322	0.10%
Community Mental Health Center					$820	$2,992	$3,812	0.00%
Family Planning Clinic					$188		$188	0.00%
FQHC				$1,580		$163,175	$164,755	0.18%
HCBS						$563,273	$563,273	0.63%
Home Health						$159,351	$159,351	0.18%
Hospital – General			$561		$408,233	$10,955,423	$11,364,217	12.66%
Hospital – Mental						$307,268	$307,268	0.34%

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Independent Laboratory				$16,829,730	$34,924,527	$1,507,467	$53,261,724	59.3%
Non-Physician Practitioner – Group		$2,126	$6,111	$7,702	$5,345	$987,111	$1,008,396	1.12%
Nurse Practitioner				$370	$395	$185	$950	0.00%
Nursing Facility					$8,376	$62,517	$70,892	0.08%
Optometrist				$1,060	$119	$1,272	$2,450	0.00%
Osteopath	$1,228		$1,412	$106			$2,746	0.00%
Pharmacy			$59,795	$83,827	$142,640	$53,848	$340,110	0.38%
Physician		$3,920	$5,040	$10,115	$3,424	$23,747	$46,245	0.05%
Podiatrist		$983		$671		$37,172	$38,826	0.04%
Psychiatric Residential Treatment Facility						$2,322	$2,322	0.00%
Rehabilitation Agency						$962	$962	0.00%
Residential Child Care Facility						$921	$921	0.00%
Rural Health Clinic				$951		$824	$1,775	0.00%
Speech Therapist						$1,128	$1,128	0.00%
Substance Use Disorder – Clinics						$440	$440	0.00%
Supply			$123,512	$1,103,057	$687,388	$4,132,919	$6,046,875	6.74%
X-Ray Facility						$8,627	$8,627	0.01%
Total	$17,199	$91,832	$281,310	$18,435,979	$36,426,075	$34,508,656	$89,761,052	

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower number of providers audited than in later years.

Exhibits 44 and **45** include the number and dollar value of complex audit claims for all provider types. As shown in **Exhibit 44**, over 96% of all claims that underwent a complex audit during Fiscal Years 2018 through 2023 pertained to General Hospitals, representing the largest share by provider type. As shown in **Exhibit 44**, General Hospitals also accounted for almost 95% of complex audit claims by dollar value.

Exhibit 44: Number of Complex Audit Claims by Provider Type and Fiscal Year

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Clinic – Dental		1	3				4	0.00%
Clinic – Practitioner	9		30			215	254	0.26%
Community Mental Health Center						48	48	0.05%
Dialysis Center						6	6	0.01%
Family Planning Clinic						3	3	0.00%
FQHC		4	6	1	1	18	30	0.03%
HCBS						2	2	0.00%
Hospice					125	2,519	2,644	2.67%
Hospital – General	972	4,202	11,759	23,846	16,497	38,284	95,560	96.5%
Hospital – Mental						3	3	0.00%
Indian Health Services – FQHC			1	7	2	4	14	0.01%
Non-Physician Practitioner – Group						27	27	0.03%
Pharmacy						175	175	0.18%
Supply						255	255	0.26%
Total	981	4,207	11,799	23,854	16,625	41,559	99,025	

Source: BerryDunn analysis of audited claims data provided by HCPF.

1 – Due to the change in HCPF's claims system, for State Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For SFY 2018, it was 4 years; for SFY 2019, it was 5 years; and for SFY 2020, it was 6 years. This accounts for the lower number of providers audited than in later years.

Exhibit 45: Dollar Value of Complex Audit Claims by Provider Type and Fiscal Year

	FY [1]							
Provider Type	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**	**Percent**
Clinic – Dental			$13,542				$13,542	0.01%
Clinic – Practitioner	$3,271		$138,001			$438,798	$580,071	0.29%
Community Mental Health Center						$49,528	$49,528	0.02%
Dialysis Center						$2,029	$2,029	0.00%
Family Planning Clinic						$1,196	$1,196	0.00%
FQHC		$26,191	$4,866	$7,965		$10,230	$49,252	0.02%
HCBS						$10,414	$10,414	0.01%
Hospice					$242,118	$9,450,586	$9,692,704	4.78%
Hospital – General	$1,385,875	$6,392,291	$15,114,332	$49,358,881	$33,367,909	$86,472,376	$192,091,665	94.70%
Hospital – Mental						$0 [1]	$0	0%
Indian Health Services – FQHC			$2,933	$36,797	$6,884	$8,031	$54,645	0.03%
Non-Physician Practitioner – Group						$30,550	$30,550	0.02%
Pharmacy						$77,938	$77,938	0.04%
Supply						$184,658	$184,658	0.09%
Total	**$1,389,146**	**$6,418,482**	**$15,273,674**	**$49,403,643**	**$33,616,911**	**$96,736,335**	**$202,838,192**	

Source: BerryDunn analysis of audited claims data provided by HCPF

1 - The three "Hospital – Mental" complex audit claims in the data provided did not include claim values.

2 – Due to the change in HCPF's claims system, for Fiscal Years 2018 through 2020, the lookback period was less than 7 years. For FY 2018, it was 4 years; for FY 2019, it was 5 years; and for FY 2020, it was 6 years. This accounts for the lower number of providers audited than in later years.

Statistic # 6 - Number and Proportion of Providers That Contested Audit Findings

Exhibit 46 quantifies the number of unique providers (based on provider NPI) per Fiscal Year that contested audit findings through either a request for Informal Reconsideration or an appeal. These data are disaggregated by automated and complex audit types. The provider count is unique within each Fiscal Year; however, the same providers may be included in multiple Fiscal Years.

Exhibit 46: Providers Requesting Informal Reconsiderations or Filing Appeals

SFY	# of Providers That Requested an IR - Automated Audits	# of Providers That Requested an IR - Complex Audits	# of Providers That Appealed - Automated Audits	# of Providers That Appealed - Complex Audits
2018	1	18	0	10
2019	13	48	6	21
2020	16	76	1	31
2021	49	75	5	32
2022	53	64	16	35
2023	213	128	43	42
Source: BerryDunn analysis of audited claims data provided by HCPF.				

Other State RAC Staff Qualification Requirements

Statute required that our evaluation include "An assessment of requirements imposed by other states in regard to overall Recovery Audit Contractor staffing and qualifications of reviewers to ensure alignment of specialty and subspecialty expertise for conducting initial audits and final determinations." [Section 25.5-4.301(3.7)(a)(III)(A), C.R.S.] We asked our subset of eight states for information about the qualifications they require of their RAC staff. Only two states – Georgia and Oregon – were willing to provide such information. Both states had requirements similar to HCPF's – that the RAC employ certified coders and licensed nurses to perform RAC audits as well as licensed physicians with appropriate specialties (such as osteopathy or psychology), when needed.

We also researched RAC programs online but could not find information on the requirements imposed by other states in terms of the qualifications of RAC staff. For three RAC vendors, we found information online about the kinds of staff they employ, as shown below. However, we could not determine if all the staff types listed were required by the state's Medicaid agency.

- Hawaii. The Hawaii RAC Program website states that its RAC, Myers and Stauffer, employs certified accountants, Certified Fraud Examiners, and medical coders, as well as licensed pharmacists, clinicians, and other specialists to perform RAC audits.
- Minnesota. The webpage for the Minnesota RAC Program states its RAC, Myers and Stauffer, employs experienced and certified coders, registered nurses, specialized therapy professionals, and licensed physicians to perform RAC audits.
- Mississippi. The Mississippi RAC Program website states that its RAC - LaunchPoint Ventures dba Discovery Health Partners - employs experienced physicians, certified coders, statisticians, and credentialed clinical reviewers to perform RAC audits.

Appendix A – Survey of Providers

We developed a survey of Colorado Medicaid providers to get their perspectives on the RAC program. The survey contained 28 questions with a mix of multiple choice, satisfaction ranking, and open response. The survey respondents were given the option to provide a free response after each multiple choice and satisfaction ranking question. There were also open response questions at the end of the survey should respondents want to provide more information or share their opinions. The first four questions were used to obtain general information about the respondent, such as the provider type and location. These questions were asked to assess whether concerns and comments were limited to certain provider types or locations of the state. The information was also used to assess the level of satisfaction among different provider types and areas of the state.

To reach as many of the roughly 1,627,702 providers enrolled in Medicaid as of October 2023 as possible, we used several methods to notify providers of the survey and provide them a survey link, as follows:

- We sent the survey link by email to 4,162 providers that had undergone RAC audits since 2018. From the emails sent, about 3,100 apparently reached the provider, while about 1,000 were electronically rejected by the addressee's email system. Further, 996 were opened and 2,105 were not.
- HCPF provided the survey link in a RAC webinar for providers in November 2023.
- HCPF included the survey link in emails sent to 624 providers who are signed up to receive RAC program updates.

In analyzing the results of the survey, we assigned the following number of points for each scaled question:

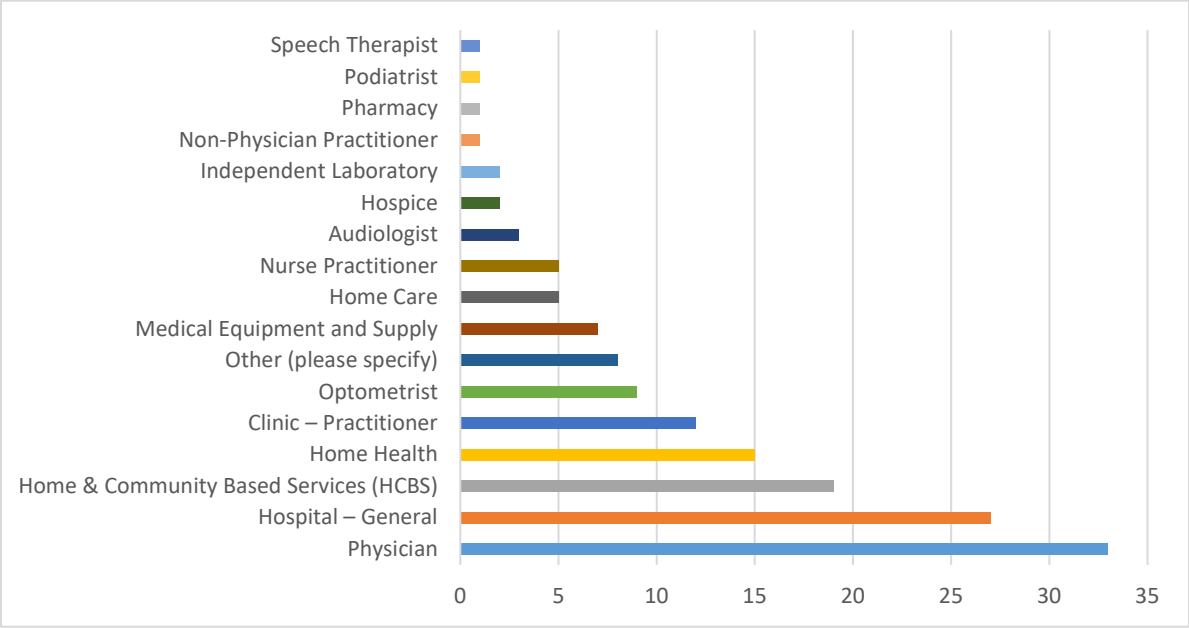
- Strongly disagree/strongly dissatisfied = 1
- Disagree/dissatisfied = 2
- Neutral = 3
- Agree/satisfied = 4
- Strongly agree/very satisfied = 5

This weighting was then multiplied by the number of responses for each question to calculate a weighted average. Based on this method, we considered a weighted average of less than three as an indicator of dissatisfaction, while a weighted average of three more indicating satisfaction.

In total, 115 providers responded to the survey, representing an 18.4% response rate overall, although some did not respond to all questions. The responses to the scaled questions are shown in the following graphs along with the number of responses to each question.

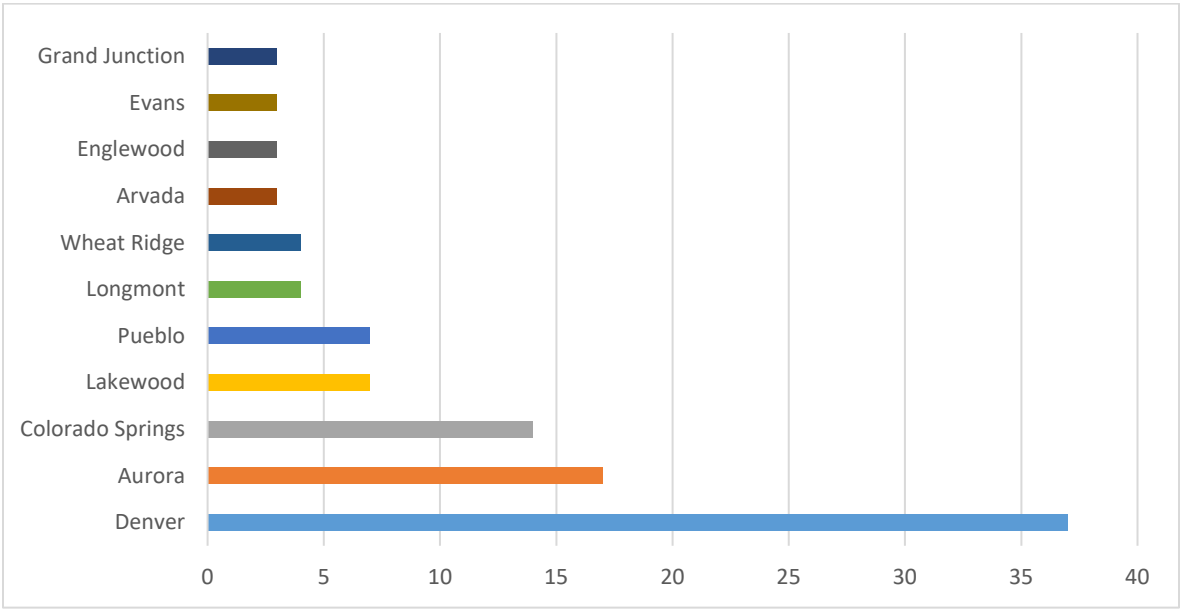
Survey Question No. 1: What is your licensed provided type?

Exhibit A-1: Results of Survey Question 1



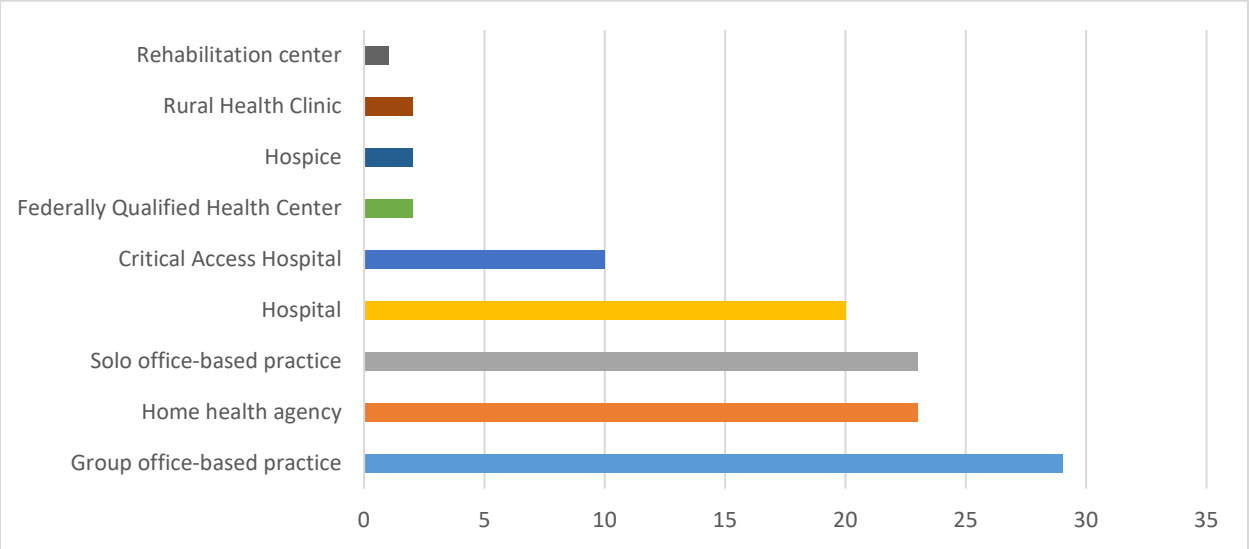
Survey Question No. 2: In what city is your primary practice located? If your practice is located outside of Colorado, please note the state.

Exhibit A-2: Results of Survey Question 2



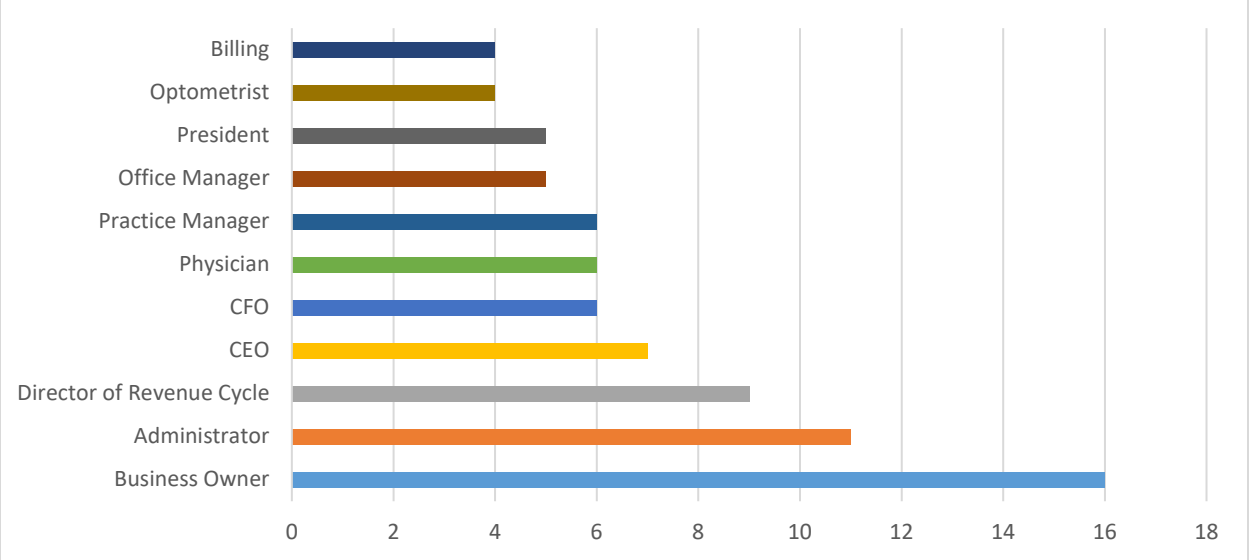
Survey Question No. 3: How would you classify your organization?

Exhibit A-3: Results of Survey Question 3



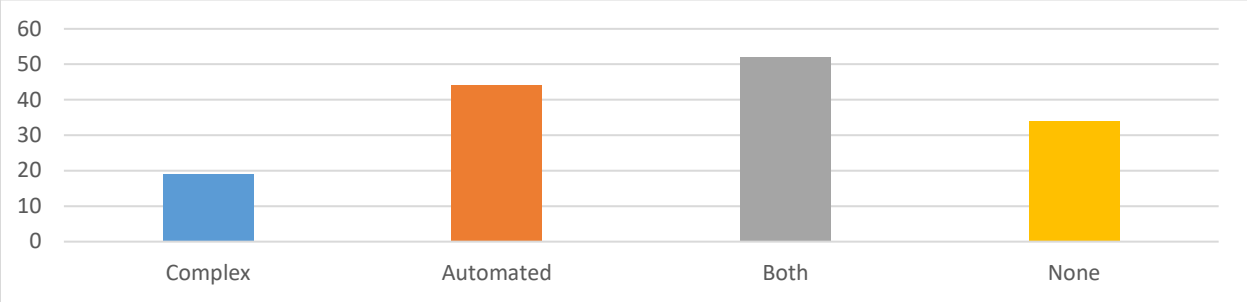
Survey Question No. 4: What is your position or job title at your organization?

Exhibit A-4: Results of Survey Question 4



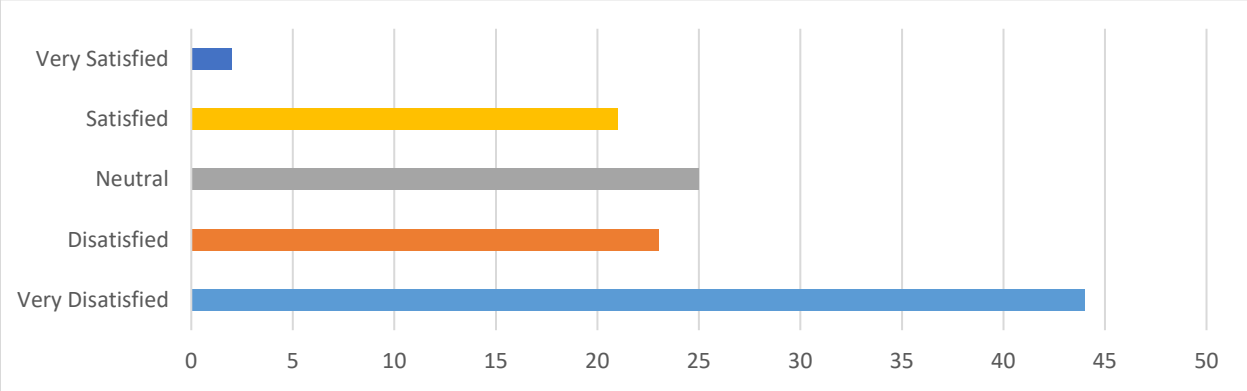
Survey Question No. 5: Which type(s) of Colorado Medicaid RAC audit has your organization participated in?

Exhibit A-5: Results of Survey Question 5



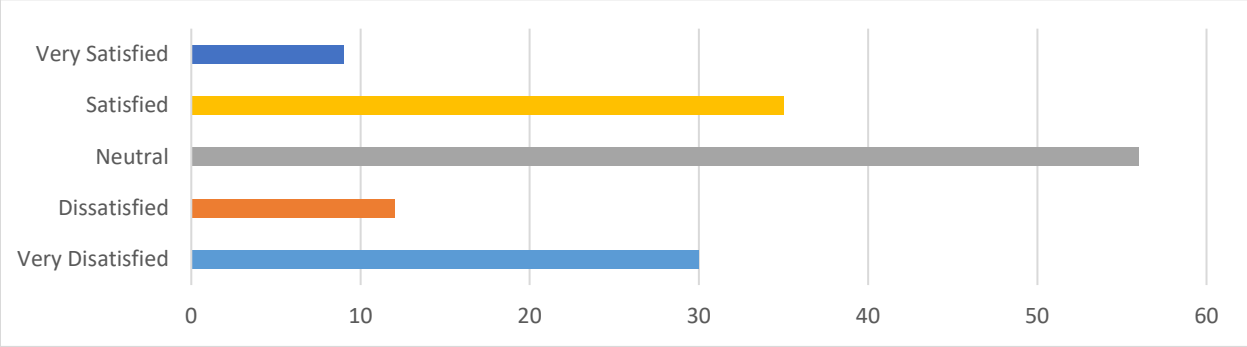
Survey Question No. 6: How would you rate your overall satisfaction with the Medicaid RAC process? *Weighted average of 2.25*

Exhibit A-6: Results of Survey Question 6



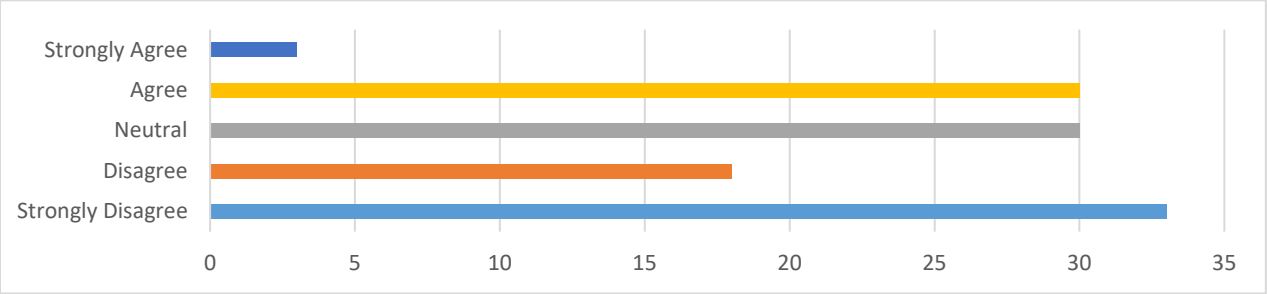
Survey Question No. 7: How would you rate the clarity and transparency of the Colorado RAC program's guidelines and regulations?

Exhibit A-7: Results of Survey Question 7



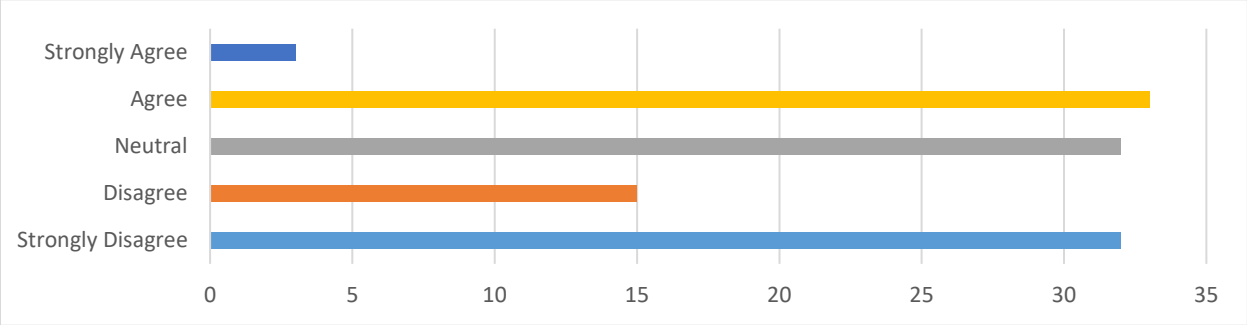
Survey Question No. 8: Did the Colorado Medicaid RAC (HMS) provide you with adequate education, training, and resources to inform you regarding the auditing and appeals process? *Weighted average of 2.58*

Exhibit A-8: Results of Survey Question 8



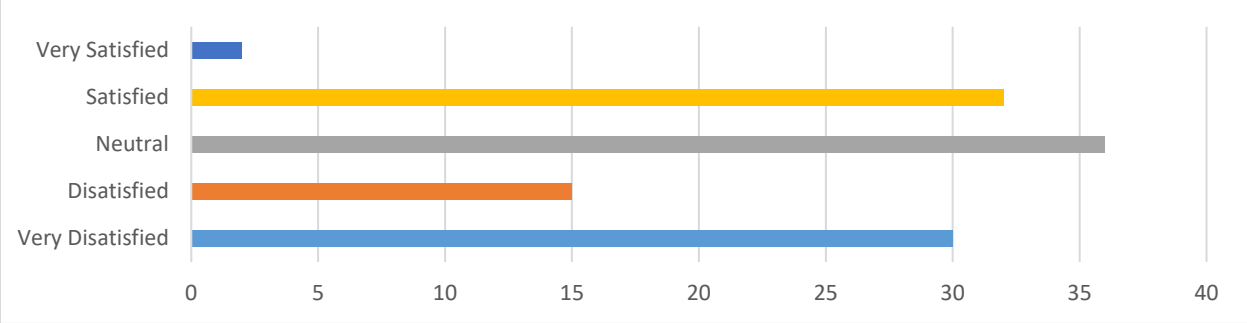
Survey Question No. 9: Were the audit selection criteria and methodologies that required your organization's participation in an audit clearly explained to you? *Weighted average of 2.65*

Exhibit A-9: Results of Survey Question 9



Survey Question No. 10: How would you rate the ease of responding to a RAC audit document request? Please consider the clarity of the request and the process for providing the requested information. *Weighted average of 2.66*

Exhibit A-10: Results of Survey Question 10

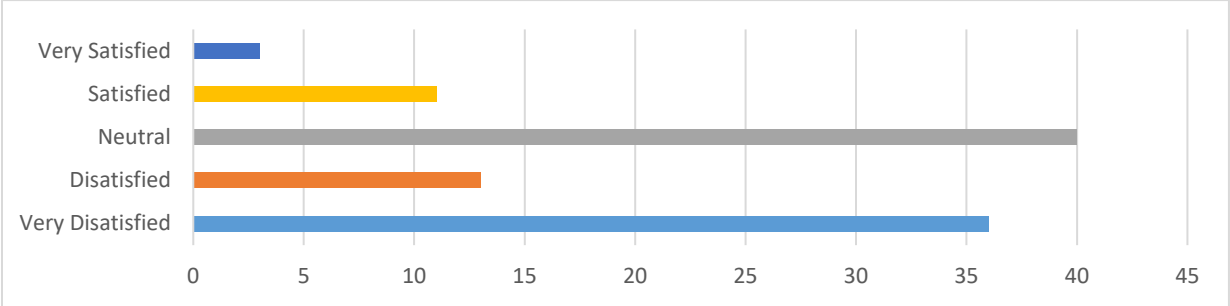


Survey Question No. 11: Has your practice filed an Informal Dispute Resolution request for the Medicaid RAC audit?

Exhibit A-11: Results of Survey Question 11

Survey Question No. 12: How satisfied are you with the transparency and fairness of the Colorado Medicaid RAC IDR process if you disputed audit findings?

Exhibit A-12: Results of Survey Question 12

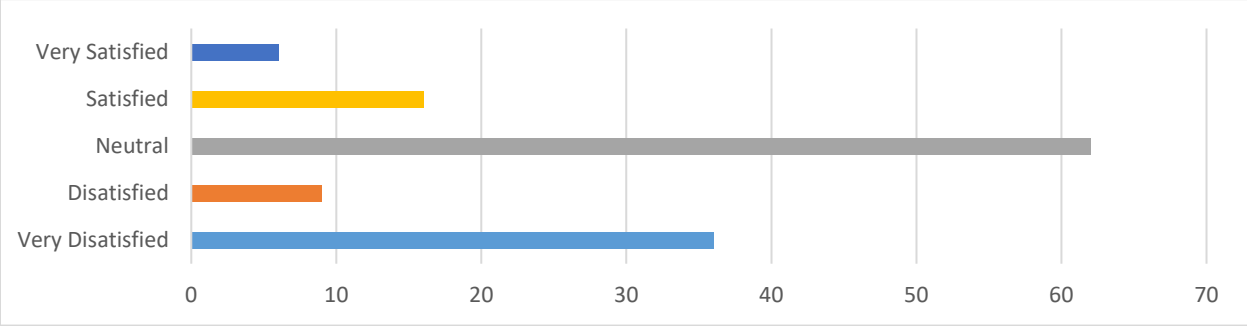


Survey Question No. 13: Has your practice filed an appeal for the Colorado Medicaid RAC audit?

Exhibit A-13: Results of Survey Question 13

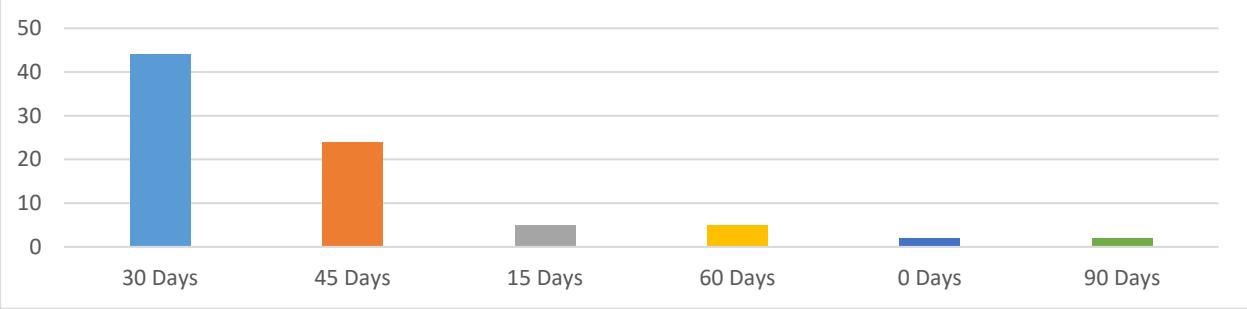
Survey Question No. 14: Do you feel that the Colorado Medicaid RAC appeal process was transparent, fair and user friendly?

Exhibit A-14: Results of Survey Question 14



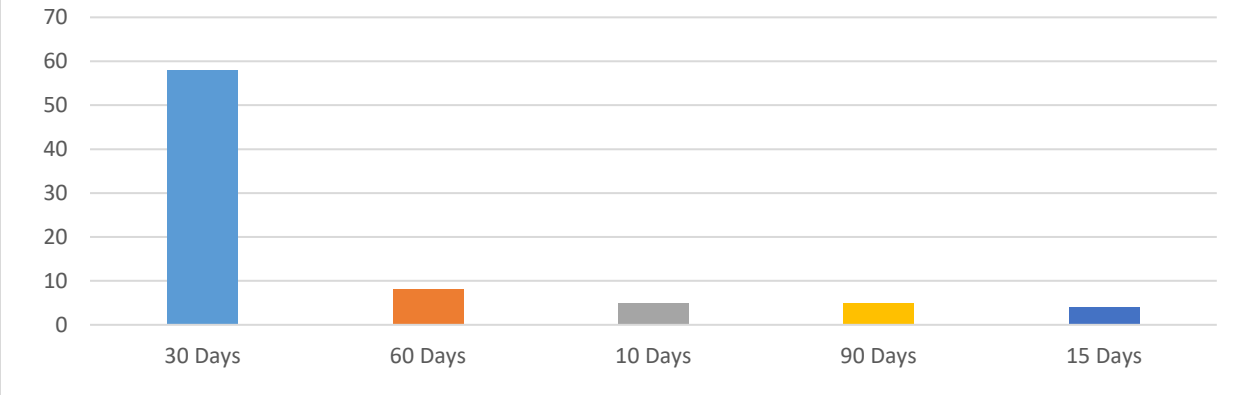
Survey Question No. 15: What is your understanding for the number of days to send records in response to a complex case review by the Colorado Medicaid RAC?

Exhibit A-15: Results of Survey Question 15



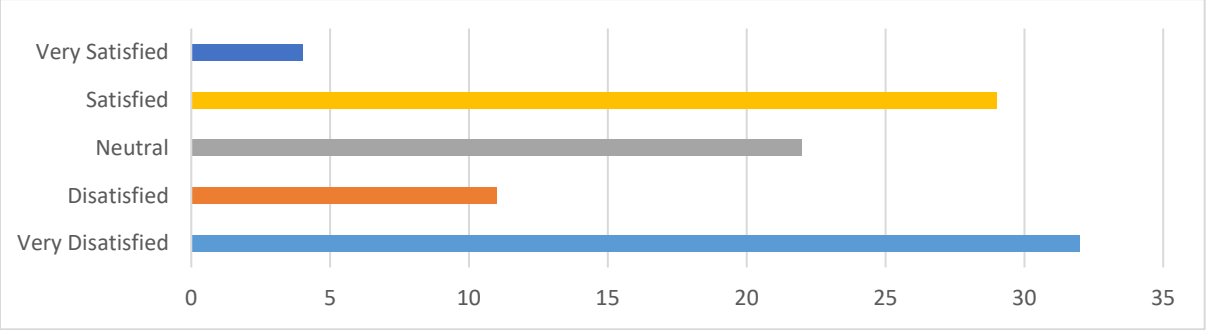
Survey Question No. 16: What is your understanding for the number of days to file an appeal?

Exhibit A-16: Results of Survey Question 16



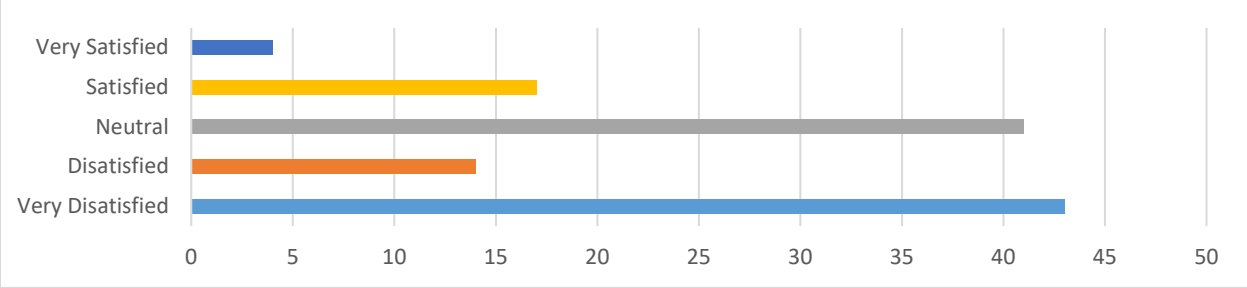
Survey Question No. 17: How would you rate the clarity of the Colorado RAC audit results and demand letters? *Weighted average of 2.61*

Exhibit A-17: Results of Survey Question 17



Survey Question No. 18: How would you rate the timeliness of RAC audit record request and the timeliness of an audit result and/or recovery demand?

Exhibit A-18: Results of Survey Question 18



Survey Question No. 19: Have you ever had a complex case audit opened by the Colorado Medicaid RAC that involved claims that were previously audited?

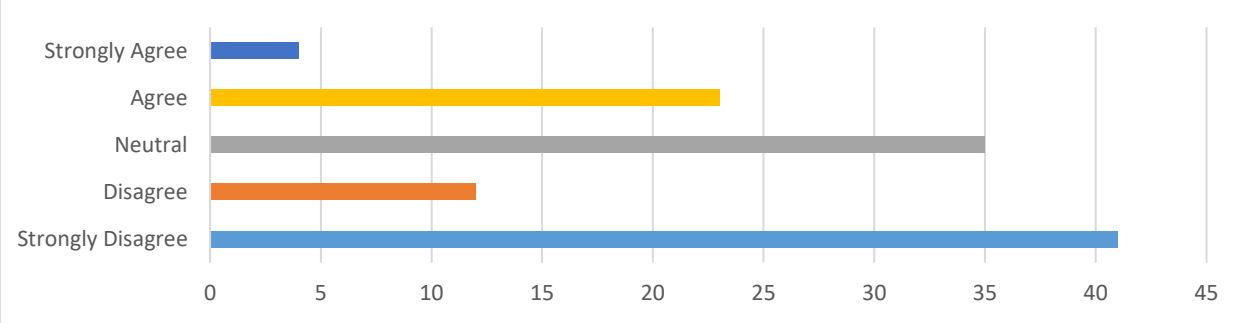
Exhibit A-19: Results of Survey Question 19

Survey Question No. 20: Have you had a complex case audit by the Colorado Medicaid RAC that involved claims for patients with dual eligibility for Medicare/Medicaid?

Exhibit A-20: Results of Survey Question 20

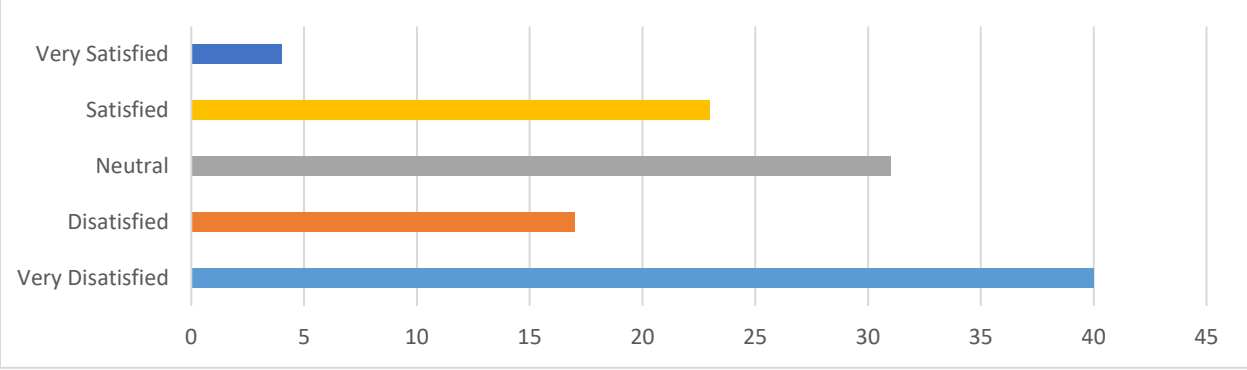
Survey Question No. 21: Do you feel that the Colorado RAC program fosters collaboration and communication between providers and auditors during the audit process?

Exhibit A-21: Results of Survey Question 21



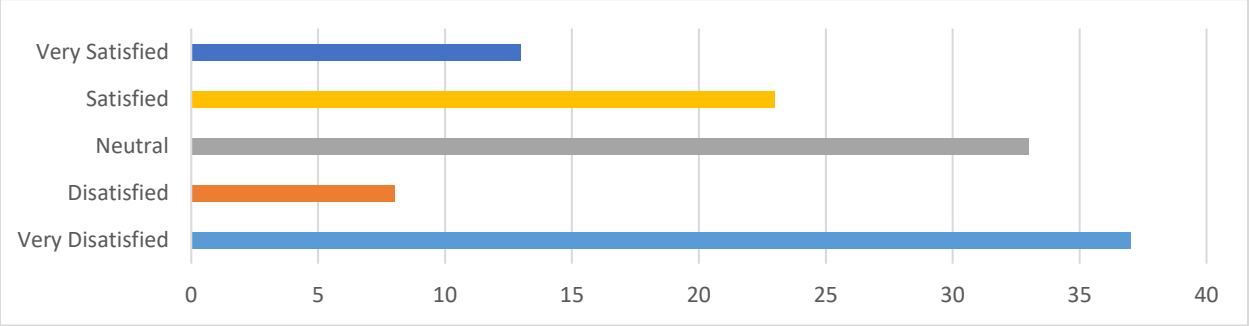
Survey Question No. 22: In your opinion, how well does the Colorado RAC program balance its role of detecting improper payments with supporting providers in compliance efforts?

Exhibit1 A-22: Results of Survey Question 22



Survey Question No. 23: How would you describe the administrative commitment required by your organization to respond to Colorado RAC audits?

Exhibit A-23: Results of Survey Question 23



Survey Question No. 24: The current lookback period is seven years. Does your organization find the lookback period poses any specific challenges? *70.53% Yes vs. 29.47% No*

Exhibit A-224: Results of Survey Question 24

Survey Question No. 25: Does your organization currently have a means or method to quantify the administrative time and cost savings that would result from a possible change in the lookback period?

Exhibit A-25: Results of Survey Question 25

In interpreting the results of the survey, we considered the potential for response bias, which is the possibility that recipients that chose to respond were motivated by a negative experience and that recipients with a neutral or satisfactory experience would not be as motivated to respond. We also took into account the low response rate. As such, we used the results only in conjunction with other analyses and reviews, as described throughout the report. We did not rely solely on survey results to conclude on any of the evaluation objectives.

We also reviewed the results of a provider survey HCPF conducted, though a third-party vendor, in June 2023. HCPF's survey was sent to 2,889 unique email addresses that represented hospitals, individual providers, and small group providers. A total of 148 providers responded, for an overall response rate of 5%. Not all providers responded to all questions. We noted that two of the questions in HCPF's survey were similar to questions in our survey. Although the questions were not identical between the two surveys, we provide the questions and responses, which show that the responses to HCPF reflected a more positive sentiment than the responses we received.

HCPF Survey Question 1: If you believe the Colorado RAC Audit Process is acceptable, please indicate so, or if you would like to provide additional information that would provide feedback to enhance the Colorado RAC Program, please proceed to the following questions. **Total Responses: 148**

> Yes, I believe the process is working adequately and have no feedback – 72%.
> I have feedback to provide and have answered the questions below – 28%.

Survey Question No. 6: How would you rate your overall satisfaction with the Medicaid RAC process? **Total Responses: 115**

> "very satisfied" or "satisfied" – 20%
> "neutral" – 22%
> "very dissatisfied" or "dissatisfied" – 58%

HCPF Survey Question 14: Do you find the information regarding Informal Reconsideration and formal appeal rights for providers published by the Department and the Colorado RAC vendor helpful? Total **Responses: 126**

> Yes - 41.3%
> No - 2.7%
> NA/I have not accessed the Department or Colorado RAC vendor websites – 46.0%

BerryDunn Survey Question 8: Did the Colorado Medicaid RAC (HMS) provide you with adequate education, training, and resources to inform you regarding the auditing and appeals process? Total Responses: 114

> Strongly Agree or Agree – 28.9%

Neutral – 26.3%
Disagree or Strongly Disagree – 45.8