National Association of Psychiatric Health Systems

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January 7, 2011

Donald M. Berwick, MD, MPP, FRCP
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-6034-P: Medicaid Program: Recovery Audit Contractors (42 CFR Part 455)

Dear Dr. Berwick,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to provide comments on the proposed rule titled "Medicaid Program: Recovery Audit Contractors" as published in the November 10, 2010, *Federal Register*. This Centers for Medicare and Medicaid Services' (CMS) proposed rule would implement provisions in the *Patient Protection and Affordable Care Act* (ACA) related to the Medicaid Recovery Audit Contractor (RAC) program.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 600 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient treatment, residential treatment, partial hospitalization, and outpatient services.

COMMENTS

NAPHS supports the efforts of CMS to identify improper or fraudulent activity in the Medicaid program. We understand that CMS has a legislative mandate to implement the Medicaid RAC program within certain timeframes. However we have serious concerns that the proposed rule does not give states sufficient guidance about the essential elements of a

Medicaid RAC program and does not fully use what has been learned through implementation of the Medicare RAC program.

We are concerned about the potentially burdensome, duplicative, and inefficient nature of the Medicaid RAC program as currently structured. States are struggling to comply with a multitude of new initiatives including requirements of healthcare reform, information technology, and the ICD-10 coding system in an environment of significant financial stress. Many states already have Medicaid Integrity Programs (MIPs) or other Medicaid audit programs in place. These have the same goals as the Medicaid RAC program and have proven effective in identifying payment inaccuracies. While states are required to maintain existing program integrity efforts at the same levels of funding and activity, they are required to add Medicaid RACs. States should be required to demonstrate that they are supplying sufficient resources to the Medicaid RAC program to provide adequate oversight of the contractors and assistance to the organizations being audited to avoid inappropriate and arbitrary RAC denials. There need to be protections in place to assure that various audit programs are not auditing the same records. A medical record request limit and look back period needs to be established. We assume records will need to be copied and mailed. This is a very significant administrative and cost burden for facilities.

The proposed rule does not sufficiently integrate what has been learned through experience with the Medicare RAC program. The refinements made to the Medicare RAC program have resulted in greater transparency and accountability in the permanent program while decreasing the incentives for aggressive payment denial that interfere with the overall goals of the program. As designed, the proposed rule could be construed to encourage aggressive payment denial as was the case in the early implementation of the Medicare RAC program. This led to costly processes of excessive record review and appeals. We are concerned that, with the short implementation window, Medicaid RACs may not be able to have in place the adequate range of well-trained staff to implement the program. There is currently no requirement that Medicaid RACs inform providers of the issues they are auditing or the criteria they are using for claims denial, including "good cause" criteria. These need to be required. We ask that medical necessity reviews not be included in the process until sufficient criteria and guidance can be developed. The proposed rule does not include provider education as an essential component of the success of the program. The goal of the RAC program is to prevent improper payments before they are made. Education is essential in this effort.

The proposed rule does not require Medicaid RACs to provide data on the number of claims appealed and the number of denials overturned during the appeals process. The rule does not prevent RACs from recouping funds from claims under appeal. The range of organizations potentially subject to Medicaid RAC review is far broader than hospitals. **Many Medicaid providers are small organizations with very tight cash margins. They cannot have funds held up in appeal and remain financially viable. This quickly leads to significant risk to beneficiary access.** Information such as appeals turnover rates, audit outcomes, accuracy of RAC determinations, validity, and extent of underpayment needs to be publicly available and closely monitored by both CMS and the states.

RECOMMENDATIONS:

To summarize, **NAPHS recommends** that CMS:

- Use its authority to exempt states from the Medicaid RAC program if the state has an adequate Medicaid integrity program in place.
- Fully integrate what has been learned from the Medicare RAC program implementation into the Medicaid RAC implementation
- Strengthen protections to providers to include information about the criteria for audits and denials, procedures for denials appeals, limitations to request for records, and requirements for adequate oversight of the Medicaid RAC program by CMS and states.
- Carefully review the potential impact of the Medicaid RAC program on small and non-hospital providers in light of the threat to beneficiary access. This is particularly important in protecting vulnerable populations such as children and persons with mental illness.

Thank you for your consideration of our comments. We look forward to working with CMS and the Department of Health and Human Services to ensure that Medicaid operates in a way that best serves its beneficiaries.

Sincerely,

Mark Covall
President/CEO