



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

December 20, 2007

Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphery Building
200 Independence Ave. SW
Washington, DC. 20201

Dear. Mr. Weems:

RE: CMS-2271-P, Proposed Rule: Medicaid Integrity Program; Eligible Entity and Contracting Requirements for the Medicaid Integrity Audit Program

On behalf of nearly 500 hospitals and health systems, and ancillary providers in the state of California, the California Hospital Association (CHA) is pleased to comment on CMS' proposed rules regarding eligible entities and contracting requirements for the Medicaid Integrity Audit Program (MIAP). In general, while CHA recognizes the utility and role that integrity auditors can play in protecting the integrity of the Medicaid program, we have had fairly substantial recent experience in the realm of provider audits through CMS' Medicare Recovery Audit Contractor (RAC) demonstration program.

Under the auspices of the RAC demonstration, California hospitals have been subject to audits and recoupment that appear to be based on unsound review of the facts, especially in the case of complex medical review audits, and are presently being overturned on a regular basis in the appeal process. Regrettably, because flaws in the design of the RAC demonstration program allow the contingency fee-based RAC contractor to keep their fee if the recoupment isn't overturned in the first level of appeal, there will be additional costs (and not savings, as was envisioned) to the Medicare program for many recoupments overturned on appeal. Additionally, the RAC demonstration has caused harm to several of our members which will not be easily rectified, and has harmed beneficiaries' ability to access care, especially for intensive inpatient rehabilitation services. CHA is anxious to do our part to assure that CMS does not repeat the mistakes it made in administering the RAC for the emerging MAIP program, and we respectfully offer our comments for CMS-2271-P, which are constructed to provide CMS with sufficient perspective to try to help CMS avoid that eventuality.

Definition of an Eligible Entity

The MIAP Eligible Entities Should Have Prior Experience in Medical Claims Review

In the RAC demonstration program, CMS selected a contractor who had no experience auditing of Medicare claims, and several had no prior experience performing medical necessity review. Consequently, providers audited by contractors in the demonstration states, including California, experienced a number of recovery audits involving care provided that was consistent with practice and policy based on Medicare's interpretive guidelines and interactions with Medicare's Fiscal Intermediaries (FIs). Though many of these administrative errors were corrected as the RAC contractors gained experience and with medical claim review, this lack of experience caused unnecessary administrative burden to providers, and created inefficiencies in the RAC review and recovery auditing process as

providers, CMS, the FIs, and the RAC contractors worked to overcome this barrier to appropriate claims review.

Eligible Entities Should Have Appropriate Clinical Capacity to Conduct Medical Necessity Review

In the RAC demonstration the contractor chose to engage in medical necessity review, which is a process that involves in-depth review of a patient's medical record in order to determine whether the treatment given to the patient was appropriate, reasonable and necessary. However, the California RAC contractor did not initially employ a medical director to oversee this review process, relying instead upon nursing staff to review the decisions of physicians that were made, in many cases, several years prior. Further, the RAC contractor's medical director, once he was employed, had little experience in making or reviewing clinical decisions made by specialists outside his range of experience and proficiency. This has led to a recent finding by AdvanceMed, a CMS contractor, that approximately 40 percent of inpatient rehabilitation claims being inappropriately denied. The contractor's findings were disclosed in a letter from the Administrator to members of the California Congressional delegation. Moreover, many more of these claims are in the process of being overturned in the Medicare appeals process at the qualified independent contractor (QIC) and administrative law judge (ALJ) levels of appeal, leading us to believe that the actual proportion of claims being inappropriately denied by the RAC contractor to be much higher than the 40 percent cited.

Consequently, CHA believes that medical review, which reviews the actions and decisions of providers up to and including a physician, should be conducted in consultation with a provider with similar education and experience. For medical necessity review therefore, we urge CMS to require the MIAP contractors employ medical directors from the outset of claims review. Further, we strongly recommend that CMS require that complex medical decisions made by physician specialists and specialized mid-level providers be reviewed by a physician from a like specialty.

Contractor Functions

The MAIP Contractor Should Allow Providers to Electronically Track the Status of Claims

A major frustration that California hospitals have experienced with the RAC demonstration contractor is a persistent lack of communication between the RAC contractor and the provider regarding the status of claims under review. CMS should require that the MAIP contractor publish the status of claims under review on a secure, password-protected website, where a provider may see the status of all claims under review, and thereby be able to plan accordingly.

Competitive Procedures and Requirements

The MIAP Contractor Should Not Be Retained on a Contingency-Fee Basis

CHA believes that most of the abusive behavior exhibited by the RAC contractor in California can be directly attributed to the contractor's contingency-fee based compensation arrangement with CMS. Though we note that unlike the MMA, the DRA does not require that the contractor be retained on a contingency-fee basis, we caution CMS away from this compensation scheme with the MIAP contractor. We believe that the contingency-fee arrangement with Medicare RAC contractors, coupled with a policy that allows the RAC contractor to retain their fee if the appeal isn't overturned in the first level of administrative appeal provided the RAC contractor with every incentive to recoup, even if the recoupment is with little merit. Indeed, as we have mentioned above, CHA has found that the RAC contractor's decisions, especially those involving medical necessity review, have been almost uniformly

overturned at the QIC and ALJ levels. However, because these levels are beyond the first (fiscal intermediary) level of appeal, the RAC contractor keeps the contingency fee regardless.

We therefore urge CMS to use less novel contracting procedures in engaging the services of the MAIP contractor. Tying contractor payment to the volume of claims denied creates a perverse incentive to irrespective of the claim's true merits, thereby gaining at least temporary access to the contingency fee (potentially providing a substantial source of capital) even for those recoupments which are later overturned on appeal, thus risking arbitrage.

The Provider Should Retain Funds from the Claim Until All Viable Sources of Appeal Are Exhausted
The RAC demonstration project in California has been so intrusive as to permanently damage the financial viability of several health care organizations in the state, thereby altering the market – and beneficiaries' access to care – permanently. The principal origin of providers' financial distress have been RAC recoupments that have cost institutions hundreds of thousands of dollars per week in some cases, and driven several into insolvency. In many cases, the bulk of claims from these damaged providers were later overturned in the appeals process, however the interruption to cash flow and operating funds that the recoupment proved too much for several providers, whose margins prior to the RAC demonstration were already low.

Therefore, we urge CMS to allow providers to retain funds recouped as part of MIAP contractors' work until all viable sources of appeal are exhausted. Though we acknowledge that this is not common practice, we observe that it is within the Secretary's authority to administer the recovery program under the Social Security Act § 1885. Given California providers' experience with the gratuitous recoupments during the RAC demonstration project, we believe that this would be a necessary and reasonable safeguard against abuse of the provider by CMS' audit contractors.

The California Hospital Association is pleased to have an opportunity to comment upon the Center for Medicare & Medicaid Services' proposed rule CMS-2271-P: Medicaid Integrity Program; EligibleEntity and Contracting Requirements for the Medicaid Integrity Audit Program. Please contact John Rigg at 202-488-4688 or jrigg@calhospital.org; or Pat Blaisdell at 916-552-7553 or pblaisdell@calhospital.org if you have any questions or require additional information.

Sincerely,



John Rigg, MHA MPA
Vice President, Federal Regulatory Affairs



Pat Blaisdell
Vice President, Centers for Medical
Rehabilitation & Continuing Care
Services

JR/PB:
Attachment

Attachment: Letter from Kerry Weems to Representative Lois Capps (CA-23)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 07 2007

The Honorable Lois Capps
House of Representatives
Washington, DC 20515

Dear Ms. Capps:

Thank you for your letter about the operation of the Recovery Audit Contractor (RAC) demonstration project being conducted in California. The Centers for Medicare & Medicaid Services (CMS) has been working cooperatively with the California Congressional delegation and the California Hospital Association to specifically address concerns related to the review of inpatient rehabilitation facility (IRF) claims during the RAC demonstration.

I would like to address your specific concerns and discuss what you can expect to see with respect to nationwide implementation of this important new program.

My staff first discussed the RAC program with the California delegation at a meeting on August 1, 2007. After that meeting, CMS instructed the RAC in California to cease the review of specific IRF claims -- this action became known as the "pause" referenced in your letter. The purpose and nature of the pause was to allow for an independent review of claims denied by the RAC but which earlier had been paid to IRFs. We conducted this review by tasking another contractor, AdvanceMed, to independently review a sample of 30 claims that had been previously reviewed by the RAC in California as well as discussing IRF medical review with other Fiscal Intermediary medical directors.

With respect to the reviews of IRF claims conducted in California, it is clear that the RAC, fiscal intermediary (FI), our independent review entity, as well as appeal contractors involved have not consistently applied our coverage and payment policies for IRF services. For example, AdvanceMed agreed with the California RAC on more than 60 percent of the cases they reviewed; however, on the remaining cases, they did not agree.

I am taking three steps as a result of this review. First, we are conducting detailed education sessions with the RAC, the FI, AdvanceMed, and the appeals contractors involved on the medical review of IRF claims. I invite you and your staff to participate in these sessions. Second, once the training is complete, I am directing the RAC to re-review all IRF claims where they previously found an overpayment using consistent medical review methodology under the demonstration, including claims that are under appeal. I will direct the RAC to initiate repayment to the provider on any reversed cases. Finally, I am directing that the RAC suspend review on any IRF claim in its system that has not yet been reviewed based on the medical necessity criteria so that it can focus on ensuring that the IRF reviews conducted to date are completed using the information provided in our education sessions.

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I want to emphasize my commitment to the RAC program and to the process they use to make their decisions. The actions I am taking here are specific to RAC review of IRF claims only. RACs have been able to recover past improper payments, and given that the overall appeal (12.5 percent) and reversal (5.5 percent) rates are quite low, I believe the RACs are a good tool to use in protecting the Medicare program. However, I now have a greater understanding of the need for enhanced education on our IRF policies specifically, which will become part of our nationwide implementation of this program.

The pause on reviewing new IRF claims will remain in effect through the end of the demonstration, which is March 27, 2008. This is because under the terms of the demonstration contract, the last day for a RAC to request medical records from a provider was December 1, 2007.

As we near the completion of the demonstration, now would be an appropriate time to provide some information on our efforts to meet the statutory requirements to implement the program nationwide. I want to assure you that we are taking into account the input from providers and Members of Congress about what went well with the demonstration, as well as where the demonstration fell short. These lessons learned have helped us formulate an implementation strategy that should mitigate some of the problems we saw with the demonstration.

As you know, the law requires that we implement recovery auditing in all states by January 1, 2010. Our primary focus in carrying out this mandate is to reduce, to the maximum extent practicable, any confusion or uncertainty on the part of physicians, hospitals and other providers. To that end, we will implement the program on a rolling basis, beginning in 2008, on a schedule that is tied to our timeline for procurement of Medicare Administrative Contractors. This strategy allows each RAC adequate time to perform outreach to health care providers prior to activities beginning in their state and mitigates any potential conflicts with MAC transition timelines. I am attaching a chart which shows how this transition will be implemented nationally.

Under this strategy we began our procurement this fall and plan to have awards made for each of the four RAC jurisdictions by April. Actual claims review in the 50 states would then phase in over the following 18 months. Note that under our proposed schedule, hospitals and physicians in California will not receive RAC-related requests for medical records until some time after October 2008, and no request will be made for medical records related to services provided before October 1, 2007.

We have also made changes to the national program based on our experience to date with the demonstration States. For example:

- Unlike with the demonstration, RACs as implemented nationally will be required to have a medical director.

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- We are limiting the amount of time that a RAC can “look back” for improper claims to a maximum of 36 months, but under no circumstances before October 1, 2007. In other words, no claims from before October 1, 2007 will be reviewed in the national program. Not until October 1, 2010 will RACs be able to exercise the maximum 36-month “look back” for improper claims.
- We are requiring that if a RAC determination is overturned at any level of appropriate administrative or judicial review, then the RAC must refund any associated contingency fee collected.
- We have established nationwide limits on the number of medical records that a RAC may request.
- We have established a new process whereby RACs notify CMS of any new issues they wish to investigate after only 10 claims have been reviewed. In this way, CMS coverage and policy experts can determine whether RACs need to be educated in the review policy before beginning widescale reviews.

I am enclosing a side-by-side comparison chart illustrating these and other changes we are making to the national program. Many of these changes have already been incorporated into the demonstration operations. For example, the RACs have already agreed to return fees when claims are overturned at the ALJ level of appeal; the RACs have all hired medical directors, even though we do not require it under their contract; and the new issue review process described above was implemented for the demonstration in September.

As you can see by the many reforms we have put into place, we are taking your concerns very seriously by working to balance the legitimate concerns of the hospital and physician community with an effective implementation strategy for this program.

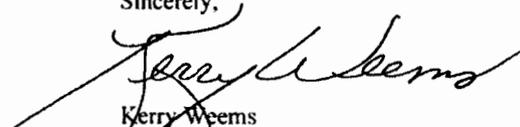
Finally, we believe recovery auditing is a valuable tool in the Medicare program, both in terms of recovering past improper payments and in helping CMS to prevent improper payments in the future. Within the past month, we announced that for 2007 the Medicare fee-for-service claims payment error rate has dropped to 3.9 percent, from 4.4 percent last year. The RAC program is an important component of our overall strategy to continue this positive trend in reducing claims payment errors.

Thank you for bringing your concerns and your constituents' concerns about the RAC demonstration program to my attention. In doing so, you have helped us refine and improve the program. More specifically, these findings have greatly influenced our development of the national program and are translating into significant program reforms that should provide for greater transparency and improved performance with respect to this national initiative.

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I share your commitment to making sure this important program works and look forward to continuing to work with you on this issue. I will also provide this response to the co-signer of your letter.

Sincerely,



Kerry Weems
Acting Administrator

Enclosures

CC The Honorable Pete Stark
The Honorable Dave Camp
The Honorable Charles Rangel
The Honorable Jim McCrery
The Honorable Max Baucus
The Honorable Charles Grassley