



## Illinois Hospital Association

October 31, 2007

### **Technical Bulletin #305: CMS Region V Meeting Discussions and Update on Medicare Contractor Activities**

Over the past several weeks, in addition to the plethora of Centers for Medicare and Medicaid Services' (CMS) publications addressing specific Medicare payment rules, the Illinois Hospital Association has been monitoring other activities/priorities that will impact not only the administration of the Medicare program, but your operations as well. On October 16, staff from CMS Region V met with state hospital association and provider staff (including IHA) to discuss current items of interest. This bulletin will provide you with a current status report on five of those activities: Medicare Contractor Reform, the Medicare Recovery Audit Project, Critical Access Hospital cost report audits, Medicare Advantage and Medicare bad debt audits.

#### **MEDICARE CONTRACTOR REFORM:**

CMS continues to move forward in its acceptance of bids and awarding of contracts to the newly-designated "Medicare Administrative Contractors" (MACs). Last week, the agency awarded its fourth and fifth contracts; following is a listing of the contracts awarded to date:

- i. Highmark Medicare Services, Inc. (Jurisdiction 12: Delaware, Maryland, New Jersey, Pennsylvania and the District of Columbia. Awarded October 26, 2007.)
- ii. Palmetto GBA. (Jurisdiction 1: California, Hawaii, Nevada, American Samoa, Guam and the Northern Mariana islands. Awarded October 26, 2007.)
- iii. Wisconsin Physicians Health Insurance Corp. (Jurisdiction 5: Iowa, Kansas, Missouri and Nebraska. Awarded September 4, 2007.)
- iv. Trailblazer Health Enterprises (Jurisdiction 4: Colorado, New Mexico, Oklahoma and Texas. Awarded August 3, 2007.)
- v. Noridian Administrative Services, LLC. (Jurisdiction 3: Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Awarded July, 2006.)

Illinois is one of three states in Jurisdiction 6 (also including Wisconsin and Minnesota). CMS has already begun to receive bids and is scheduled to award a contract to our region by the fall of 2008, with transition to the new contractor scheduled to be completed in 2009.

As part of the contract award process, CMS has been surveying providers soliciting their opinions on the performance of their current Part A or Part B contractor. The selection of providers is on a random basis. At the CMS/State Hospital Associations Region V meeting, CMS staffers stated that this survey information was important in the contractor selection process. **So if you are the recipient of a Medicare contractor satisfaction survey, IHA encourages you to complete and submit it.** Also, please contact the Association if your facility has been chosen, so that an accurate number of surveyed members can be determined.

#### **MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROJECT:**

You may have already heard or read about the Medicare Recovery Audit Contractor (RAC) project. The Medicare Modernization Act of 2003 established this program as a "demonstration project" in

three states (California, Florida and New York) to identify improper Medicare payments for hospital inpatient and outpatient services, as well as physician and skilled nursing facility services. Both overpayments and underpayments made by Medicare to the providers were to be identified and reconciliations made. The initial project focused on claims spanning four years (October, 2001–September, 2005) and claims were selected randomly. Among the reasons for incorrect payment are:

- i. Medicare improperly billed as the primary payer
- ii. Fiscal intermediaries' payment errors
- iii. Medical necessity of the services provided
- iv. Coding errors

The pilot project yielded financial results that overwhelmingly favored recovery of monies by the Medicare program: approximately \$68.6 million in overpayments was collected, while \$2.9 million in underpayments was paid. The costs incurred were approximately \$14.5 million. Therefore, the net recovered by the Medicare Trust Fund was \$51.2 million.

Consequently, the Tax Relief and Health Care Act of 2006 elevated the project from “demo” status to “permanent” status and expanded the effort to include all fifty states. As of this writing, the review has already been expanded to include Arizona, Massachusetts and South Carolina, with reviews of claims in all states scheduled to begin by October, 2008. Letters should be mailed to providers before summer of 2008. If the facility wishes to challenge the findings of the RAC, an appeal process is established. CMS also assured attendees at the October 16 meeting that RACs will be consistent when applying Local Coverage Decisions (LCDs) developed by the provider's Medicare Fiscal Intermediary or Carrier when reviewing claims for medical necessity. As of this writing, the identity of the Illinois Recovery Audit Contractor is not known. While the extent of the sample size is also unknown, what CMS has indicated is that the RACs can select claims dating back three years from the date of payment.

IHA continues to monitor developments with this process and will communicate any new information to you as it becomes available. As this is also a national issue, the American Hospital Association is also keeping a pulse on it, and as new information from other states becomes available, that too, will be shared with you.

#### **REVIEWS OF CRITICAL ACCESS HOSPITAL COST REPORTS:**

As part of its work plan for both 2007 and 2008, the Office of the Inspector General (OIG) has indicated that it will be reviewing cost reports filed by critical access hospitals to ensure that costs claimed and reimbursed to those hospitals comply with Medicare regulations. This process has begun, although nationally at this time, only a small number of hospitals have been selected. The review is expected to apply to cost reports spanning a three-year period. Again, the IHA will be monitoring developments as they occur and will continue to communicate with the AHA to gauge the extent of this review on a national level. In the meantime, if your hospital is selected for audit, please inform IHA and be prepared to have all the necessary documentation available in order to justify your costs claimed in the Medicare cost report.

#### **MEDICARE ADVANTAGE UPDATE:**

This was another topic of which an update was given by Mr. Ray Swisher of CMS at the October 16 meeting. CMS continues to look critically at Medicare Advantage (MA) plans, paying particular attention to the Private Fee for Service (PFFS) plans. About a year ago, IHA published a bulletin detailing several problem areas that IHA members were having with MA. These problem areas included:

- i. Patient / Plan identification
- ii. Accuracy of payment rates (in particular, for out-of-network providers)
- iii. Lack of a payment reconciliation process
- iv. Lack of timely or informative responses from Plans' staffs to providers' inquiries

Over the past year, the Illinois Hospital Association has maintained a regular dialogue with Mr. Swisher; he has been very responsive to members' concerns. While not all is perfect, it appears that improvements have been made. Just recently, IHA was made aware that one of the plans included a reconciliation clause in its provider contract. Plan identification on the individual's membership card is clearer. CMS has been made aware that plans' "traditional" Medicare payment should include adjustments such as indirect medical education, disproportionate share, outliers or capital where applicable. Again, all the problems are far from fixed, but progress is being made. IHA encourages you to inform the Association about *any* issues or problem areas that your facility is facing relative to Medicare Advantage plans. At the very least, these concerns can then be forwarded to CMS for follow-up.

#### **MEDICARE BAD DEBT AUDIT ISSUES:**

As you are no doubt aware, Medicare audits involving reimbursement for bad debts continue to become more stringent. The latest issue involves the requirement that unpaid deductibles or co-insurance for Medicare/Medicaid ("dual-eligible") accounts cannot be reimbursed through the Medicare cost report unless notification from Medicaid is received that it will not pay the claim. Upon receipt of that notification (usually in the form of a Medicaid remittance advice), the provider can then claim the amount as recoverable through the cost report.

About a month ago, IHA was made aware of a situation in Indiana whereby the fiscal intermediary (National Government Services) was disallowing bad debts for dual-eligible claims because a copy of the *electronic* remittance advice was given to the Medicare audit staff in lieu of an original paper copy. This is disturbing because the same information is contained on both documents. The Indiana Hospital Association raised this concern with National Government Services' (NGS) audit staff, who reiterated that current CMS instructions require the presentation of an original remittance advice and not an electronic copy. However, NGS did state that it would seek further guidance from CMS on this issue.

To IHA's knowledge, this audit issue has not been experienced by IHA member hospitals; however, if your facility has experienced disallowed bad debt amounts because of this approach, please inform the Association. Also, if possible, please indicate the impact of this adjustment on the extrapolation to the entire Medicare bad debt amount claimed. CMS will be interested in knowing the dollar impact of this adjustment during our discussions. Also, there is a meeting of the NGS Quad-State hospital coalition on November 8 in Indianapolis; further information on this issue should be presented then, and will subsequently, be communicated to you.

IHA hopes this information is useful to you. If you have any questions or comments, contact [Tom Jendro](#): (630) 276-5516.