Health and Human Services Committee
LB 315
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Good afternoon Senator Campbell and members of the Health and Human Services Committee, my name is Jeanne Larsen (J-E-A-N-N-E L-A-R-S-E-N), deputy director for Claims and Program Integrity within the Medicaid and Long-Term Care division of the Department of Health and Human Services. I am here to testify in opposition to LB 315.

LB 315 proposes changes to the 2012 state law allowing Medicaid to use contingency-based contracts to promote the integrity of the Nebraska Medical Assistance Program (NMAP) and to assist with cost containment efforts and recovery audits. In my testimony today, I will address our concerns with LB 315.

First and foremost, the nature of this bill is contradictory to the purpose and principles of Program Integrity, which is to prevent and combat provider fraud, waste, and abuse, as well as to recover improper payments on behalf of the federal and state government.

Medicaid pays for services that are "medically necessary" and covered by Medicaid. Our first concern is the introduction of the term "reasonably necessary." "Reasonably necessary" is not a standard of care that is reimbursable at the state and federal levels, and the use of this term could set a precedent with unintended consequences to the Medicaid program. In addition, activities aimed at providing reimbursement for improperly billed but "reasonably necessary" services is outside the scope of the contract and would represent a conflict of interest.

The guidance to the States from the federal Centers for Medicare and Medicaid Services (CMS) was to adopt elements from the Medicare Recovery Audit Contractor (RAC) program, including medical necessity reviews. Medicaid and its agents would be negligent in identifying - but not pursuing - a case where the provider's medical records did not substantiate a preauthorized service or subsequently submitted charges.

Medicaid regulations state, "Payment for a service does not indicate compliance with NMAP policy. Monitoring may be accomplished by post-payment review to verify that NMAP policy has been followed. A refund will be requested if post-payment review finds that NMAP payment has been made for claims/services not in compliance with NMAP policy." Thus, allowing reimbursement for a procedure, service, item, etc. billed erroneously for any length of time is contrary to state and federal regulations as well as the principals of good program integrity.

Another concern with language in the bill regards medical documentation and records:

- A documentation request by the Medicaid Division or one of its agents is not an adverse action, so in keeping with state and federal regulations, it is not an appealable action.

- State and federal regulations require that “Service records be retained as are necessary to fully disclose the extent of the services provided to support and document all claims, for a minimum period of six years…” and to “Allow federal, state, or local offices responsible for program administration or audit to review service records”.
- Reimbursement to providers for documentation they are required to keep and provide would have significant fiscal impact. The expenses would be a pass-through to Medicaid, and since this is not eligible for federal reimbursement, would be state-funded. Additionally, this action could set a dangerous precedent to reimburse for any records related to other Medicaid program reviews, investigations and audits, and those activities and audits performed by entities at the federal level.

Lastly, the bill provides that should the Department or the hearing officer find that the contractor’s determination was unreasonable or frivolous, the contractor shall reimburse the provider for provider’s costs associated with the appeal. First, the responsibility of the Department, contractor, and the hearing office is to make determinations based on Medicaid rules and regulations. Introducing ambiguous terms of unreasonable and frivolous and maintaining any level of consistency in their application would be difficult at best. Secondly, the bill does not define costs, or explain how the provider’s costs would be determined, or how payment of the costs would be enforced. It is not clear whether costs would include attorney’s fees. Agencies are not currently authorized to award attorney’s fees under the Nebraska Administrative Procedure Act. If costs include attorney’s fees, this bill may set a precedent for other programs and agencies. Since the contractor may be required to pay for costs, it is possible that the contractor would be a necessary party to the appeal. This would greatly complicate the appeals process.

I will add that many components of this bill are already covered by Medicaid and the RAC. These include benefit reconsiderations when adjustments for underpayments are presented, an established appeals process to include a discussion period and two-level review, correspondence containing claims and client-specific information, utilization of the same universal and standard medical coding conventions as providers, use of appropriate medical resources for medical reviews, notifying providers of audit results to include specific claim detail, repayment of contingency-fee payments when RAC determinations are vacated, a web site dedicated to NE Medicaid’s RAC activities, and the ability to submit clinical documentation and records to the RAC in a variety of formats including paper, electronic and digital.

In closing, the proposed requirements would also increase state funding and administrative costs, and would likely mean the renegotiation or re-procurement of the RAC contract. In addition to reimbursement for medical records and expenses associated with appeals, there would be costs associated with expanding the administrative and appeal processes, provider outreach efforts, reporting requirements, and look-back period. For identified overpayments on services billed in error but considered to be reasonably necessary and for those billed in error for 5 years or more, repayment of federal funds are still required. Therefore, funding of billing errors and those deemed not medically necessary would be at 100% of state funds.

For all of the above reasons, the Department opposes LB 315.

I am happy to work with the other parties and answer any questions you may have.

Issues with LB 315
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Federal issues:

- Program Integrity is responsible for preventing fraud, waste, and abuse as well as erroneous payments. So the very nature of this bill is contrary to the federal law on PI expectations.

- Excluding recovery of consistently billed but inaccurate claims or improper payments is not permissible under state/federal rules and regulations. Improper payments must be recovered. Regardless of whether they are recovered, repayment must be made to the federal government.

- Federal requirements mandate that RACs identify and recover overpayments, and identify underpayments. It's a conflict of interest with the purpose of the RAC to mandate a consideration on what is believed to be "the appropriate reimbursement."

- While the Centers for Medicare and Medicaid Services (CMS) provided an allowance to exclude managed care organizations (MCOs), and Nebraska elected to do the same, legislation to exclude them all together would prevent future opportunities to include them. Additionally, the federal HHS Office of the Inspector General has recommended to CMS additional oversight/scrutiny of claims payments by MCOs.

- CMS guidance for state Medicaid agencies allows for medical necessity reviews.

- The federal law allows state Medicaid agency to determine the number of records that may be requested depending on the initial investigation preceding the referral to the RAC scenario.

- Payment for records is not allowable. As per the Service Provider Agreement, the provider agree "That service records will be retained as are necessary to fully disclose the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPPA Section 164.530(j)"; and to "Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20-74.24; and 42 CFR 431.107".

- There is no state or federal definition for "unreasonable and frivolous" findings.

Potential Unintended Consequences

- Legislation that prevents recovery of improper billing would set a precedent for all Program Integrity activities and efforts – potentially being a defense for fraudulent activity. The gravity of this would also extend to overall claims billing going forward – which we'd be unable to predict the effect of that.

- Reimbursement for records

- Reimbursement for expenses related to overturned appeals