Senate Committee on Aging

Improving Audits: How We Can Strengthen the Medicare Program for Future Generations

July 9, 2014

We are very pleased to participate in this roundtable and would like to thank Chairman Nelson, Ranking Member Susan Collins, and the rest of the Committee for inviting us. We represent First Coast Service Options (First Coast), which is the Medicare Administrative Contractor (MAC) for the jurisdiction that includes Florida, Puerto Rico and the U.S. Virgin Islands. Prior to becoming a MAC, First Coast, and its predecessor company has served Florida's fee for service Medicare population and the providers who care for them since the inception of the Medicare program in 1966.

As a MAC, we are responsible for a number of key activities, including:

- Processing Part A and Part B (or fee for service) Medicare claims, except DME and Home Health,
- Processing first level provider and beneficiary appeals of initial claim determinations,
- Providing service to Medicare providers by answering written and telephone inquiries,
- Processing provider enrollment applications,
- Developing local medical policies, known as Local Coverage Determinations (LCDs),
- Performing prepayment fraud prevention activities that are unique to our jurisdiction,
- Providing support to law enforcement and other stakeholders,
- Developing data driven provider education programs,
- Ensuring accurate fee for service reimbursement for Part A providers by setting interim payment rates and auditing provider cost reports,
- Performing provider and beneficiary debt collection and referral activities

Specifically as it relates to audit activities, which is the subject of this roundtable, we conduct pre-pay and post payment Medical Review. Our Medical Review framework is data driven and uses multiple data sources, such as our own claims-based data warehouse, Comprehensive Error Rate Testing Results, and national data sources such as the Part B analytics system and the Chronic Conditions Warehouse coupled with staff that includes both statisticians and clinicians so that we can determine where there are program vulnerabilities and undertake the appropriate actions to successfully address these. The analysis of data can lead to the identification of service-wide anomalies at the procedure code level or provider specific reviews. Whenever possible we begin by determining what can be done through provider education and then we move through the Progressive Corrective Action (PCA) process as needed. The PCA process is designed to align the identified risk to the program with the corrective action to ensure it is proportional and consistent with the Medical Review guidelines we follow where we reimburse legitimate providers for reasonable and necessary services that are coded correctly, use the least intensive intervention possible, move providers on and off review quickly and do reviews on a pre-pay basis whenever possible.

At First Coast, we pride ourselves on our collaborative approach to administration of the Medicare fee for service program in our jurisdiction and we work extensively with hospital associations, medical societies, the Centers for Medicare & Medicaid Services, and other Medicare contractors such as the Recovery Auditors, the Zone Program Integrity Contractor, the Comprehensive Error Rate Testing Contractor and key stakeholders such as the Office of Inspector General, and Government Accountability Office to safeguard the Medicare Trust Fund and ensure our administrative processes are as effective as possible. We participate for example every other month in a meeting with one of the Recovery Auditors which is scheduled and facilitated by one of the state hospital associations. This meeting is intended to raise issues and concerns the hospitals are experiencing with the auditing process, ensure awareness and to the extent possible reach agreement on how issues can be mitigated. These types of communication forums can be very effective in helping all of us understand how we can work better together to the benefit of the fee for service Medicare program and the beneficiaries who rely upon it.

We are committed to improving payment accuracy and agree there are opportunities to identify and implement process improvements that will lead to a reduction in improper payments including extensive provider education, continued cooperation among all stakeholders, including the organizations gathered here and the use of tools such as the Recovery Audit Data Warehouse so that we eliminate or minimize duplication of efforts.

Thank you again for the invitation to participate and we look forward to a helpful roundtable discussion.