Federation of American Hospitals®

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Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-6041-NC
Hubert H. Humphrey Building
200 Independence Ave, SW., Room 445-G
Washington, DC 20201

RE: Medicare Part C Program: Recovery Audit Contractors
Solicitation of Comments: CMS – 6041-NC
75 Fed. Reg. 81278-81280 (December 27, 2010)

Dear Dr. Berwick:

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching community hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer and psychiatric hospitals. We appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' ("CMS") development of a Recovery Audit Contractor ("RAC") program for Medicare Parts C and D, as required by the Patient Protection and Affordable Care Act of 2010 ("ACA"). The FAH's comments below will be limited to expansion of the RAC program for Medicare Part C.

In the Solicitation of Comments, CMS reiterates that the main objectives of a RAC program are the return of overpayments identified by the RAC to the Medicare Trust Fund and the prevention of future improper payments. CMS also acknowledges that their experience is limited to the Medicare fee-for-service ("FFS") program and recognizes that fundamental differences exist between the Medicare FFS and Part C. The FAH commends CMS for soliciting the views of industry stakeholders on how best to expand the RAC program and for its acknowledgment that accomplishment of this task will be extremely challenging.

Issue: Methods for the RACs to identify underpayments and overpayments in Medicare Part C.

FAH Response: The FAH concurs with CMS that the unique structure of Medicare Part C presents significant challenges to expansion of the RAC program, especially in identifying underpayments and overpayments under Medicare Part C that would necessarily result in federal

savings. It would be virtually impossible for a RAC reviewer to determine whether the payment is correct for a single claim when there is no dollar for dollar correlation between what is paid and the costs associated to the MA Plan and CMS. Rather, there is a complicated payment structure that is based upon principles of competition, bidding methodologies, numbers of enrollees, estimates of expected costs, utilization of services, and various risk adjustments and payment options. The whole system is based on fixed amounts negotiated through individual CMS/MA Plan/provider contracts – each with their own unique characteristics based on many variables – not on a particular price per service. Moreover, for inpatient services (including post-acute hospital services) many MA plans use admission criteria or preauthorization processes that can be more restrictive than those used in fee-for-service Medicare. In addition, some use proprietary guidelines to which providers have no access in the absence of costly subscription fees. Concurrent review is also utilized by MA plans, so patient cases are reviewed during the entirety of the inpatient stay. Post-discharge, it is not unusual for MA plans to request medical records to further scrutinize the claim prior to payment.

Simply put, CMS contracts with public or private organizations to offer beneficiaries health plan options that, at a minimum, provide the same benefits covered under the original Medicare program, but at a potentially reduced cost. The Medicare program pays a fixed amount to the MA Plan and in turn, the MA offers multiple types of MA plans to its enrollees and contracts with providers/suppliers to provide the health care services.

The following illustrates the complexity inherent in Part C. The payment structure for local and regional MA Plans is based in part on a bid from the MA organization that takes into account an estimate of their expected costs for providing enrollee health care benefits in the particular plan's service area. As detailed in Chapter 1 of the *Medicare Managed Care Manual*, CMS Pub. 100-16, § 10:

> "Our payment to an MA organization for an MA plan's coverage of Original Medicare benefits depends on the relationship between the plan's basis A/B bid and a "benchmark" amount established for that county as required by statute. For a plan with a basic A/B bid below its benchmark, we pay the MA organization the basis A/B bid amount, adjusted by the individual enrollee's risk factor, plus a rebate amount determined by law. The rebate is used to provide mandatory supplemental benefits and/or reductions in Part B or Part D premiums. For a plan with a bid equal to or above its benchmark, we pay the MA organization the benchmark, adjusted by the individual enrollee's risk factor."

As detailed further in 42 C.F.R. § 422.308, CMS performs the following calculations and adjustments to determine rates and payments:

> a) a national per capita growth percentage;
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> b) an adjustment for over or under projection of national per capita growth percentages;

c) risk adjustments (e.g., for age, gender, disability status, institutional status, and other factors CMS determines to be appropriate, including health status);

d) an adjustment for intra-area variations;

e) an adjustment relating to risk adjustment: the government premium adjustment;

f) an adjustment of payments to reflect the number of Medicare enrollees;

g) an adjustment for national coverage determination services and legislative changes in benefits; and

h) adjustments to payments to regional MA Plans for purposes of risk corridor payments.

Based on this analysis, CMS determines the amount to be provided to the MA Plan from the Medicare Trust Fund. In turn, the MA Plan offers multiple plan options at a variety of costs to its Medicare enrollees that include the following: 1) coordinated care plans (e.g., health maintenance organizations, provider sponsored organizations and preferred provider organizations); 2) Medicare medical savings accounts; 3) private fee-for-service; and 4) religious fraternal benefit plans. The MA Plan subsequently contracts with providers and suppliers, using varying rate arrangements, to provide the health care services.

Given this payment structure, it seems impossible to correlate the per claim payment with the actual amount paid by the Medicare program. There is no dispute that the RAC reviewer could review a particular issue for compliance with the Medicare coverage requirements, as in the Medicare RAC program (e.g., determine an inpatient versus outpatient stay, determine the level of DRG, or determine an incorrect procedure code). However, in the Medicare Part C program, failure of the specific claim to meet Medicare coverage requirements does not correlate directly to the payment structure between CMS and the MA Plan. Therefore, how the RAC would be able to identify an overpayment or underpayment that impacts payments by the government to MA organizations remains a mystery.

Issue: Utilizing a phased-in approach for RACs under Medicare Part C.

FAH Response: While the FAH is skeptical that expansion of the RAC program to Medicare Part C will address CMS's primary end point, savings to the Medicare Trust Fund, if such a process is developed, the FAH supports the use of a phased-in-approach for a significant period of time to allow for both implementation of the program and an evaluation of its effectiveness. That phase in should focus on the traditional issues identified for the RAC programs under Medicare Parts A and B during the demonstration project -- medical necessity, DRG validation, and short stays and the like – and not only apply the important lessons learned from the demonstration and incorporated into the permanent program, but also avoid issues that may be uniquely driven by the terms of agreements between an MA Plan and individual hospitals, such as carve outs of special services like dialysis or rehabilitation services from Medicare rates. The RAC contractors cannot be expected to accurately ascertain the terms and conditions of such

agreements. We suggest limiting the initial phase to these issues so that utility of the use of RACs under Part C can be benchmarked to a known database of results. This initial phase should last three years to allow time for appeals from adjustments imposed in the first year of the program to be resolved as part of such benchmark analysis. Also, in this first phase, CMS may choose to limit claims review to payments under the Part C Patient Fee for Service Plans because those plans most closely mirror traditional Medicare.

Issue: Criteria or qualifications necessary to enable a RAC to knowledgeably and appropriately review payments under Medicare Part C.

FAH Response: For purposes of claim review, the FAH recommends that CMS require the RAC, at a minimum, to maintain the same criteria and qualifications for its management team and personnel that is utilized in the Medicare RAC program. There should be a physician-driven program, with sufficient oversight of nurses, therapists, and other applicable disciplines to ensure that claims are appropriately reviewed and evaluated in accordance with applicable coverage requirements. The RAC should have a minimum of one full-time Medical Director with relevant work and education experience, and an alternate when the Medical Director is unavailable for extended periods of time. The Statement of Work ("SOW") should also identify the Medical Director's necessary work experience, educational experiences and primary duties. In addition, when performing complex coverage or coding reviews, the SOW should require the RAC to ensure that initial coverage/medical necessity determinations are made by RNs or therapists and that coding determinations are made by certified coders. The RAC must also ensure that it shall comply with provider requests to discuss any denials with the Medical Director.

Understanding the complexity of the payment structure of Medicare Part C is also essential to the accuracy of a RAC review as mere knowledge of Medicare coverage requirements will not be sufficient. Therefore, the FAH strongly recommends that the RAC be required to engage personnel highly experienced in contract review and the unique reimbursement structure between CMS, the MA Plans and providers.

In addition, given ACA's expansion of the RAC's role to include an evaluation of the effectiveness of the MA Plan's anti-fraud program, the FAH strongly recommends that CMS require the RACs to maintain sufficient staff highly trained in the development and implementation of anti-fraud plans and the necessary compliance and monitoring processes that are essential to determining the ongoing success of an anti-fraud plan.

Issue: Specific conflict of interest rules that should apply to RACs under Medicare Part C.

FAH Response: The FAH seeks clarification on what is meant by "conflict of interest rules." However, the FAH recognizes the potential for a conflict of interest should CMS allow the MA Plan to engage the RAC within its own operations. If CMS allows the MA Plan to pay the RAC on a contingency fee basis for all overpayments identified and the MA is not required to repay the Medicare Trust Fund for that contract year, then the MA Plan and the RAC obtain a windfall. Given the complex criteria utilized in determining the negotiated bids between CMS and MA Plans and the uncertainty that a future contract would remain in place, it is unclear as to whether overpayments arising from prior contracted years would have any bearing in future rate determinations and that cost-savings to the Medicare Trust Fund would occur. In addition, the

MA and RAC's relationship would likely deter the identification of any underpayments made by the MA Plan to the provider.

Issue: Establishment of an oversight entity for Medicare Part C RAC issue approval.

FAH Response: The FAH strongly recommends that there be a unified oversight process that applies to all Medicare and State Medicaid RAC programs to ensure the maintenance of an efficient RAC program that minimizes provider burdens, ensures accuracy and maximizes transparency. Therefore, the FAH supports implementation of an oversight entity for Medicare Part C RAC issue approval.

Issue: Methods for resolving underpayments and how payments related to underpayments identified by the RAC would be implemented under Part C.

FAH Response: The FAH seeks clarification as to why this question relates only to resolving underpayment situations and does not reference overpayments. As discussed above, the MA Program is based on a multi-tiered non-consistent contractual payment system. There is no dollar for dollar correlation as in the Medicare FFS model. Therefore, the question should relate to resolving differences in payment – both from an overpayment perspective and underpayment. Based on the discussion above, it is unclear to the FAH how the process for identifying and collecting/refunding of overpayments and underpayments can be addressed in the current MA Program model. Nonetheless, the FAH will only support a RAC program that provides for the consistent emphasis on reviewing claims for both overpayments and underpayments, since the main goal of any audit is to ensure proper payment of the claim.

Issue: Potential for allowing Part C Plans to use RACs within their own plans to identify overpayments in operations.

FAH Response: According to CMS's discussion in the Solicitation of Comments, this initiative could involve RAC contractors entering into agreements with MA Plans to conduct claims review, with the RAC being paid by the MA Plan on a contingency fee basis and the MA Plan retaining the recouped overpayments.

The FAH has concerns with allowing MA Plans to engage the RAC within their own plans to identify overpayments in its operations without sufficient CMS oversight. It is the FAH's understanding that CMS anticipates utilizing overpayment determinations as a means for recalculating their future contracts with the MA Plans. However, having the relationship between the oversight body (the RAC) and the entity that is being investigated (the MA Plan), creates a significant conflict of interest and raises concern as to the effectiveness of the process and any bias that may occur.

The FAH also questions the effect this process would have on the MA Plan's own contractual obligations with CMS. The MA Plan is responsible for its own internal monitoring and auditing of the delivery of health care services to its enrollees, for initiating a prompt response to detected offenses, and for the development of corrective action initiatives. However, if the MA Plan were allowed to use RACs within their own plans to identify overpayments in its operations and pay them on a contingency basis for their efforts, what motivation is there for the MA Plan to expend sufficient resources to implement its own quality assurance program, when it may be more cost-effective to rely on the RAC potentially identifying an overpayment?

Additionally, as noted above, the FAH would not support a RAC program that is designed only to identify overpayments. Any MA Plan specific RAC program would need to be fair and balanced and address both overpayments and underpayments.

Issue: Use of RACs to ensure that the MA Plan has an anti-fraud plan in place and to review the effectiveness of the anti-fraud plan. CMS is interested in the industry's views on how to pay RACs on a contingency basis for reviewing anti-fraud plans in the Part C and Part D programs given that there are no recoveries or overpayments resulting from a review of such plans.

FAH Response: As discussed above, there are many uncertainties as to how the RAC program could be implemented in the current model of Medicare Part C without potential conflicts of interest and/or a rise in costs to the Medicare Trust Fund. In order to best respond to this question, the FAH seeks clarification on this process – is it a one-time evaluation or will the RAC be expected to review the effectiveness of the MA Plan's anti-fraud program on an ongoing basis? If this is determined to be an ongoing process, the RAC is likely to anticipate additional reimbursement on a non-contingent basis to address the costs for performing this administrative function. If this is a one-time service (e.g., at the beginning of the MA Plan contract), then perhaps the RAC fee should merely be included in the Statement of Work as an administrative task that is funded by CMS. In the alternative, the cost should fall on the MA Plan, since it is responsible for ensuring the prevention of fraud, abuse and waste as part of its contractual obligations with CMS.

Issue: Limitation on medical record requests.

FAH Response: The FAH will only support the same limitations as under Medicare Parts A and B regarding medical record requests. During the Medicare Demonstration Project, providers were surprised with the overwhelming record demands from the RACs and suffered huge administrative burdens in timely producing the requested records. As a result, the permanent RAC program for Parts A and B is currently required to limit record requests to 1% of all claims submitted for the previous calendar year, divided into eight periods (45 days). CMS should require a similar record request limitation under Part C to ease the administrative burden placed on the provider by the RACs and other federal and state program safeguard contractors. The FAH also recommends that CMS modify such limits as needed based on feedback from the RACs, providers and their associations. Furthermore, the FAH advocates mandated reimbursement to providers for copying and mailing costs similar to provisions under Parts A and B.

Issue: Look back period for claims review.

FAH Response: The look back period for claims review under the Medicare RAC program for Parts A and B is limited to a period of three years. However, under Part C, the look back period is an issue negotiated in the contract between the MA Plan and the provider, with some contracts only permitting a one-year look back period. The FAH supports limitation of the look back period to the specific contract provisions between the MA Plan and the provider.

Issue: Appeal process under Medicare Part C.

FAH Response: An appeal process varying with each MA Plan contract will be unduly burdensome and difficult for hospitals to track, especially for those facilities that operate under

multiple MA Plan contracts. The FAH recommends standardizing the appeal process for Part C RAC determinations to ensure consistency and to eliminate confusion. At a minimum, the Part C RAC appeals process should include the following: 1) a clearly defined appeals process describing the providers' rights and responsibilities; 2) a multi-tiered appeals process similar to Medicare Parts A and B, which provides for an independent review; 3) a process by which recoupment is delayed until the appeals process is finished or has reached a certain stage; 4) a description of how interest will be applied to overpayment determinations; 5) time frames regarding appeal deadlines, providing supporting documentation, and issuing review decisions; 6) detailed decisions describing the basis for upholding the overpayment determination and informing the provider of further appeal rights and deadlines; 7) agreements between the Part C RAC, and any other entities involved in the RAC process to ensure the timely and accurate flow of information; and 8) penalties for noncompliance with time frames that should apply to both the provider and the entity adjudicating the RAC appeal.

Issue: Recouping of funds during the appeal process.

FAH Response: The FAH recommends that CMS require a process similar to the RAC program under Medicare Parts A and B, which prohibits the recouping of funds until the first two levels of the appeal process are exhausted. This will significantly decrease unnecessary financial and administrative burdens on providers while they pursue an appeal of an overpayment determination.

Issue: Provider education

FAH Response: The FAH recommends comprehensive education to providers regarding the RAC program under Medicare Part C.

CMS requires the RACs under Medicare Parts A and B to submit a formal project plan that addresses, at a minimum, provider outreach efforts to associations, providers, Medicare contractors, and any other applicable Medicare stakeholders. In addition, prior to commencing audits, the RACs are required to conduct comprehensive outreach programs to the provider community. The FAH recommends that a similar process is adopted under Part C, with an outreach plan that addresses, at a minimum, the sharing of information on operational issues, targeted areas of vulnerabilities, identified errors, and the appeal process. CMS and the Part C RACs should work with the provider associations to ensure that sufficient education is provided to the provider community on an ongoing basis.

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The FAH appreciates the opportunity to comment on the Solicitation of Comments. If you have any questions about our comments or need further information, please contact me, Jeff Micklos or Steve Speil of my staff at (202) 624-1500.

Sincerely,