Andrea L. Devoti, MSN, MBA, RN
Chairman of the Board

HOMECARE & HOSPICE
NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD
President

April 12, 2012

Marilyn Tavenner

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attn: CMS-6037-P, Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 21244-1850

Electronic Submission: http://www.regulations.gov

Dear Administrator Tavenner:

The National Association for Home Care & Hospice (NAHC) is the largest trade association in the country representing home health agencies. NAHC members represent the entire spectrum of home health agencies, including Visiting Nurse Associations, government-based agencies, multi-state corporate organizations, health system affiliated providers, and freestanding, proprietary home health agencies. NAHC members serve nearly 3 million Medicare home health beneficiaries each year.

We are writing to request your consideration of our comments, submitted on behalf of these providers, on "Medicare Program; Reporting and Returning Overpayments" (CMS-6037-P). (Hereafter "NPRM"). NAHC and its members consider Medicare program integrity to be a very high priority for all stakeholders. The Medicare program should be refunded any provider overpayments as soon as possible and in the most efficient fashion available. As such, NAHC generally supports much of the proposed rule. At the same time, NAHC offers a few recommendations that could improve the rule and request clarifications on a couple of topics.

SELF-REPORTING of OVERPAYMENTS

The NPRM appears to propose that a provider must follow the existing voluntary refund process set out in CMS Pub. 100-06,Chapter 4 (to be renamed the "self-reported overpayment refund process") with each instance where an overpayment of any nature is identified by the provider. This reporting process requires detailed information on how the error was discovered, the corrective action plan implemented, the reason for the refund, and a number of other elements of information. CMS explains that such process must be used with respect to overpayments caused by using the incorrect service dates and incomplete CPT codes.

While this process may seem to be a well-constructed approach to accounting for overpayment refunds, it can easily become a massive paperwork burden with respect to minor errors and omissions that are typically corrected by the provider through a simple claim cancellation and submission of a corrected claim. Home health agencies and hospices have informed NAHC that such corrective actions are routine events, addressing simple matters as corrections of the episode coding in the home health benefit and billing day coding on hospice services. As proposed, these types of claim reconciliations would be insufficient to comply with the rule. Instead, for such simple corrections, the HHA or hospice will need to complete an extensive form to reach the same end point. The efficient approach currently in use encourages corrections, the proposed paperwork intensive reporting on these simple reconciliations discourages it.

NAHC recommends that CMS allow continuation of the simple claim reconciliation/correction process and apply the proposed reporting requirements only for overpayments identified outside this routine activity. For example, if an HHA identifies multiple overpayments through a periodic internal audit, the self-reporting process should be used. However, if an error is identified in a single claim through routine "double-checking," the claims reconciliation approach of cancellation and correction can be used.

10-YEAR LOOKBACK PERIOD

The NPRM proposes to include a 10-year lookback period for reporting accompanied by a change in the rules to allow a reopening of claims involved in such a reported overpayment. Numerous NAHC members have raised concerns about the record retention costs of a 10-year lookback period. In addition, concerns have been expressed regarding the responsibilities of providers to review 10 years of past claims under a standard of "reckless disregard or deliberate ignorance of whether it received an overpayment." An anonymous complaint could trigger an obligation to audit 10-year old claims just to avoid an accusation of a False Claims Act violation under the deliberate ignorance standard.

While NAHC recognizes the statute of limitations period under the False Claims Act, we suggest that there must be a better way to address the issues of focus in the overpayment refund obligation than to provide a 10-year lookback period with its concomitant (but unstated) obligation to retain claims records for a full ten years.

In addition, the final rule should make clear that it is not to be applied retroactively in any regard, including the lookback period. In other words, the ACA changes have prospective effect only and that it does not permit an application of the refund standard in the NPRM to claims that precede the ACA amendment to the False Claims Act by 10 years. Instead, it should be made clear that the "lookback" is applicable to claims only up to the enactment date of the ACA amendment to the FCA.

RECONCILATIONS

The NPRM proposes two exceptions to the general rule "that applicable reconciliation occurs with the provider's submission of a cost report." The two exceptions are inpatient hospital-related matters: DSH payments and outlier reconciliation. However, the home health services and hospice benefits also include provisions where reconciliations will occur outside the cost reporting process.

With the annual hospice cap, Medicare reconciles payments and the cap outside the cost report and usually outside the cost reporting period. Currently, the Medicare contractor conducts a post-cap year review to calculate the provider-specific cap and its status thereunder. The cap calculation is also subject to reopening when later claims are processed that would lead to a change in the calculated hospice patient census in the cap year. These recalculations are most likely if a provider elects the proportional method of cap calculation.

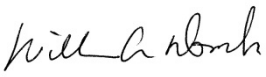
The home health benefit includes a 10% outlier revenue annual cap. While the likelihood of an overpayment occurring is minimal given the real-time application of the cap to filed claims, there is a remote risk that an overpayment could occur through post-year claims corrections.

NAHC recommends that CMS include the hospice annual cap and home health outlier revenue cap as exceptions to the cost report reconciliation exceptions set out in the NPRM. Any overpayments identified in these reconciliations should be subject to the 60 day post-identification refund standard.

NAHC further recommends that CMS establish a generic exception that covers any other reconciliations that exist outside of the cost reporting process. This catch-all exception would also avoid the need to amend the rule in the event that additional caps or payment limits are imposed that operate outside of the cost reporting process.

Thank you for the opportunity to submit these comments. We look forward to the issuance of the Final Rule.

Very truly yours,



William A. Dombi

Vice President for Law