American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

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Submitted electronically.

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Medicare Program; Solicitation of Comments Regarding Development of a Recovery Audit Contractor Program for the Medicare Part C and D Programs; File Code CMS-6041-NC

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for comments regarding the 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.

CMS should not require Medicare Advantage (MA) plans to create a separate RAC program internally for the purpose of auditing provider payments, rather the AHA urges CMS to implement the Medicare Part C RAC program in a manner that focuses on accuracy of payments from Medicare to the MA plans. For example, audits should review whether per member, per month payments are for the correct Medicare beneficiaries, enrollments and disenrollments are accurate and plan information provided to CMS is correct.

Hospitals strive for payment accuracy and are committed to working with CMS and its contractors to ensure the validity of Medicare payments. In fact, hospitals already work with Part C MA plans to identify billing mistakes and repay inappropriate payments. As you know, MA plans are at risk for any improper Medicare reimbursements made to providers; therefore, they have a strong financial incentive to ensure billing mistakes do not occur. As a result, MA plans already conduct comprehensive audits of hospital payments.

However, CMS has not implemented any restrictions on MA plan audits like those that exist for the Medicare fee-for-service (FFS) RAC program. Hospitals have experienced significant administrative burden associated with MA plan audits. As the AHA has informed CMS, hospitals have been subjected to unwieldy and constant medical records requests on behalf of the MA plans, at times receiving requests for every single claim paid by a plan. Significant resources have been expended attempting to meet the constant audit requests of the MA plans, prompting the AHA to urge CMS to adopt audit restrictions for MA plans, similar to those that exist for the Medicare FFS RAC program.

Since MA plans already conduct comprehensive audits and hospitals already expend significant resources responding to these audits, we strongly oppose CMS' proposal to require the plans to adopt an internal RAC program. The adoption of yet another government auditing program would only create more administrative burden for hospitals, divert resources from patient care and increase health care costs.

However, if CMS pursues this proposal, the agency at the very least must: a) require the MA plan to cease other audits of provider payments; b) require each MA plan to implement RAC program restrictions requested below; and c) implement penalties for MA plans and RACs that fail to comply with program requirements, including, but not limited to, those requirements listed below.

ESSENTIAL RAC PROGRAM REQUIREMENTS:

- Exclude medical necessity review (MNR) from the program. If MNR is allowed, ensure a mechanism for hospitals to re-bill for services that were medically necessary, but provided in the wrong setting.
- Require trained medical professionals to conduct RAC audits.
- Limit RACs to a 12-month look-back period.
- Necessitate close CMS oversight of RACs and specifically assign CMS staff to address provider concerns with MA plan RACs.
- Require CMS approval of each audit issue before the RAC conducts the audit.
- Invest at least 7 percent of RAC recoveries into payment system fixes and provider education.
- Enact penalties for RACs that duplicate audits and apply the wrong payment rules.
- Implement a medical record request limit.
- Require the RAC to provide a case-specific rationale for each denial.
- Implement timeframes for RAC determinations and for notification of those determinations.
- Require that RAC correspondence be sent to the correct hospital contact/address and allow an extended response time when RAC correspondence does not reach the correct hospital.

- Require RACs to have public websites listing approved audit issues and customer service contact information, tracking of open audits and a portal for hospitals to submit contact information.
- Require RACs to respond to provider inquiries within 24 hours.
- Enact a robust appeals process that includes multiple levels of appeals and allows for a "discussion period," similar to that of the Medicare FFS RAC program.
- Suspend RAC recoupment until the appeals process is exhausted and withhold RAC contingency fees when a denial is overturned.

CONCLUSION

We appreciate your consideration of these recommendations and urge you not to require Medicare Part C health plans to adopt an internal RAC program. As stated above, MA plans are already auditing providers to ensure payment accuracy. Adoption of another auditing program would result in duplicative audits that would create more administrative burden for hospitals, divert resources from patient care and drive up health care costs. Instead, we urge CMS to adopt a RAC program that would review the accuracy of payments made directly from Medicare to Medicare Part C health plans.

If you have questions about our comments, please contact me or Elizabeth Baskett, senior associate director, at (202) 626-2294 or ebaskett@aha.org.

Sincerely,

Rick Pollack
Executive Vice President