AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

February 23, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013,
Baltimore, MD 21244-8013

Attention: Recovery Audit Contractor Program for the Medicare Part C and D Programs (CMS-6041-NC)

Dear Dr. Berwick:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 97,600 family physicians and medical students nationwide, I am writing in response to the *Solicitation of Comments Regarding Development of a Recovery Audit Contractor Program for the Medicare Part C and D Programs* as published in the December 27, 2010 Federal Register.

The *Affordable Care Act* provides the Centers for Medicare & Medicaid Services (CMS) with the authority to enter into contracts with Recovery Audit Contractors (RACs) to identify overpayments and underpayments and recoup overpayments in Medicare Part C (Medicare Advantage plans) and Part D (Medicare Prescription Drug Plans). In addition to the identification of improper payments, the *Affordable Care Act* also establishes special rules for Part C and Part D that require RACs to ensure that each Part C and Part D plan has anti-fraud plans in place and to review the effectiveness of the anti-fraud plans.

In this regulation, CMS accurately recognizes the fundamental differences between the Medicare fee-for-service program and the Medicare Parts C and D programs. Under the statutory payment formula, Medicare Parts C and D plans are paid on a capitated basis. Therefore, these plans, not the government, are at direct risk for any overpayments and underpayments made to its providers. Risk of improper payments to the government lies within the calculation of capitated payments. This includes the assignment of beneficiary risk scores and payment system errors such as direct and indirect remuneration reporting. The Department of Health & Human Services (HHS) error rate for Part C plans in 2010[i] is an estimated 14.1% or $13.6 billion as identified by HHS' contractors. Thus, the AAFP is particularly concerned with CMS' interest in potentially allowing Part C and Part D plans to use RACs to identify overpayments within their own plans. This redirection of focus from the recovery of overpayments to Part C plans and decreasing the Part C error rate does not serve the statutory intent of the *Affordable Care Act*. The AAFP reminds the agency that identifying overpayments within the Part C and Part D programs ' own operations is not included in the activities for which HHS shall enter into contracts with the RACs for Medicare Parts C and D programs; rather Section 6411(b) of *Affordable Care Act* states:

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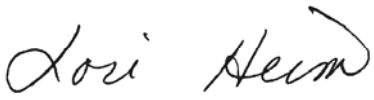
The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—
''(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;
''(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;
''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and
''(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.''.

As the AAFP and other physician organizations have previously voiced to CMS, physicians are already inundated with medical record requests on behalf of Part C plans seeking documentation of chronic conditions for which ICD-9 codes were not submitted on claims (often correctly so because the conditions were not addressed at a visit). An October 2010 report[ii] by the Kaiser Family Foundation indicates an average of 24 Part C plans operate in each county including 10 HMO's, 4 local PPO's, 4 private fee-for-service plans, 5 regional PPO's and 1 cost plan. Physicians wishing to accommodate their patients who enroll with these plans are then forced to handle each plan's specific payment policies and coding and billing instructions. The sheer number of these plans creates enormous complexities and encourages burdensome medical record documentation request letters. It is unreasonable to add to the physician's burden with contingency-based audit contractors seeking out fee-for-service based payment errors on behalf of plans paid by the government on a capitation basis. If this is done, it could reinforce a growing sentiment among physicians that providing care to Medicare beneficiaries assumes too much financial risk and is too administratively burdensome. The AAFP therefore urges CMS to limit the RAC programs for Parts C and D to those activities specifically required by Section 6411(b).

The AAFP appreciates the opportunity to provide our views on this important issue and looks forward to commenting further during subsequent rulemaking on the development and implementation of requirements for RACs in the Part C and Part D programs. If we may be of further assistance in this regard, please contact Robert Bennett, the AAFP Federal Regulatory Manager, at rbennett@aafp.org.

Sincerely,



Lori J. Heim, MD, FAAFP
Board Chair

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[i] http://paymentaccuracy.gov/programs/medicare-part-c#learnmore, accessed 02/07/2011
[ii] Medicare Advantage 2011 Data Spotlight, http://www.kff.org/medicare/upload/8117.pdf, accessed 02/07/2011